Item No. 12

Meeting Date **Wednesday 22nd October 2025**

Glasgow City Integration Joint Board Finance, Audit and Scrutiny Committee

Report By: **Kelda Gaffney, Depute Chief Officer, Operations and Governance and Chief Social Work Officer**

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Duty of Candour

Purpose of Report:	The purpose of this report is to inform the IJB Finance, Audit and Scrutiny Committee about Duty of Candour cases identified within Glasgow City Health and Social Care Partnership and of the requirements for annual reporting to the Scottish Government.

Background/Engagement:	In February 2018 The Duty of Candour Procedure (Scotland) Regulations 2018 was introduced. In July 2018 a paper was submitted to the Integration Joint Board(IJB) to provide the IJB Performance Scrutiny Committee (at that time) with an overview of the legal duty applying to health and social care services. This was effective from 1st April 2018 with recommendations made to future development and administration of the process. This process was delayed due to the HSCP response to the Covid 19 pandemic and a report was submitted to the Senior Management Team meeting on 7th August 2024 to agree actions and next steps.

Governance Route:	The matters contained within this paper have been previously considered by the following group(s) as part of its development. HSCP Senior Management Team ☒ Council Corporate Management Team ☐ Health Board Corporate Management Team ☐ Council Committee ☐ Update requested by IJB ☐

	Other ☐ Not Applicable ☐

Recommendations:	The IJB Finance, Audit and Scrutiny Committee is asked to: a) Note the content of the report; b) Note the draft report to the Scottish Government (Appendix 1); and c) Note next steps to ensure robust reporting and monitoring.

Relevance to Integration Joint Board Strategic Plan:
This is a legislative requirement of the HSCP and is required to enable the HSCP to fulfil its duties outlined within the strategic plan.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome:	Outcomes 3, 7 and 8 – improve service user experience, protect from harm, support continuous improvement
Personnel:	None
Carers:	None
Provider Organisations:	Provider organisations have their own responsibility to report and follow duty of candour legislation.
Equalities:	None
Fairer Scotland Compliance:	none.
Financial:	None
Legal:	The Duty of Candour Procedure (Scotland) Regulations 2018 is part of the Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None
Risk Implications:	Failure to comply with duty of candour would be a failure of GCHSCP to fulfil its legislative duties.
Implications for Glasgow City Council:	Duty of candour applies to Glasgow City Council delegated services provided by Glasgow City Health and Social Care Partnership. There are implications for risk and claims management.

Implications for NHS Greater Glasgow & Clyde:	Duty of candour applies to NHS Greater Glasgow &Clyde delegated services provided by Glasgow City Health and Social Care Partnership. There are implications for risk and claims management.

1. Purpose

1.1. To report to the IJB Finance, Audit and Scrutiny Committee the Duty of Candour cases identified within Glasgow City Health and Social Care Partnership and the requirements for annual reporting to the Scottish Government.

2. Background

2.1 The Duty of Candour is a statutory requirement for health and social care organisations in Scotland, designed to promote openness, transparency, and accountability when things go wrong in the provision of care.

2.2 The Duty of Candour was introduced in 2018 under the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016, with the aim of ensuring that organisations are open and honest with patients, service users and their families when an unintended or unexpected event occurs that results in harm. The legislation requires organisations to notify those affected, offer an apology, and provide support throughout the process.

2.3 The Duty applies not only to clinical incidents but also to any situation where the care provided results in death or significant harm, including physical or psychological injury. Its implementation is overseen by the Scottish Government and Healthcare Improvement Scotland, with annual reporting requirements for all relevant bodies.

2.4 Each organisation providing health and social care should also compile a monitoring process to enable annual reporting of:

- Number of incidents
- Degree to which duties were discharged
- Changes in policy and procedures resulting from an incident
- Support to staff and individuals affected

2.5 In July 2018 a paper was submitted to the Integration Joint Board Performance Scrutiny Committee to provide an overview of the legal duty applying to health and social care services with effect from 1st April 2018 and to make recommendations as to future development and administrations of the process.

2.6 Due to business continuity issues during the COVID 19 pandemic, expected actions were not implemented and the item was tabled again in August 2024 at the HSCP Senior Management Meeting to agree next steps and actions.

3. Requirements

3.1 As an organisation delivering regulated activities, the HSCP is legally compelled to fulfil the Duty of Candour requirements. This includes ensuring all incidents are identified, investigated, and reported appropriately, and that learning from such events is disseminated to prevent recurrence.

3.2 Scottish Government published revised guidance on Organisational Duty of Candour in April 2025, noting that openness and honesty should be central to the actions of those providing care to others, and at the heart of every relationship between those providing, receiving and/or experiencing treatment and care. Guidance was updated based on reviews of published annual reports, learning identified from the COVID-19 pandemic and other scenarios such as healthcare-associated infections (HAI) and incidents involving multiple people, and extensive engagement and feedback from across the health, care and social work sectors.

3.3 The HSCP (the "responsible person") is subject to the organisational duty of candour as defined in section 25 of The Act. Organisations must activate the duty of candour procedure as soon as reasonably practicable after becoming 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
  - that outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition

2.4 A 'registered health professional' is a member of a profession as defined under section 60(2) of the Health Act 1999[13]. For an incident to activate the organisational duty of candour procedure, a registered health professional must give their view on the incident, its relationship to the possible future occurrence or actual occurrence of death or harm and how the incident does not relate to the natural course of the illness or underlying conditions. The registered health professional should also detail if any additional framework is being used to support the activation of the procedure.

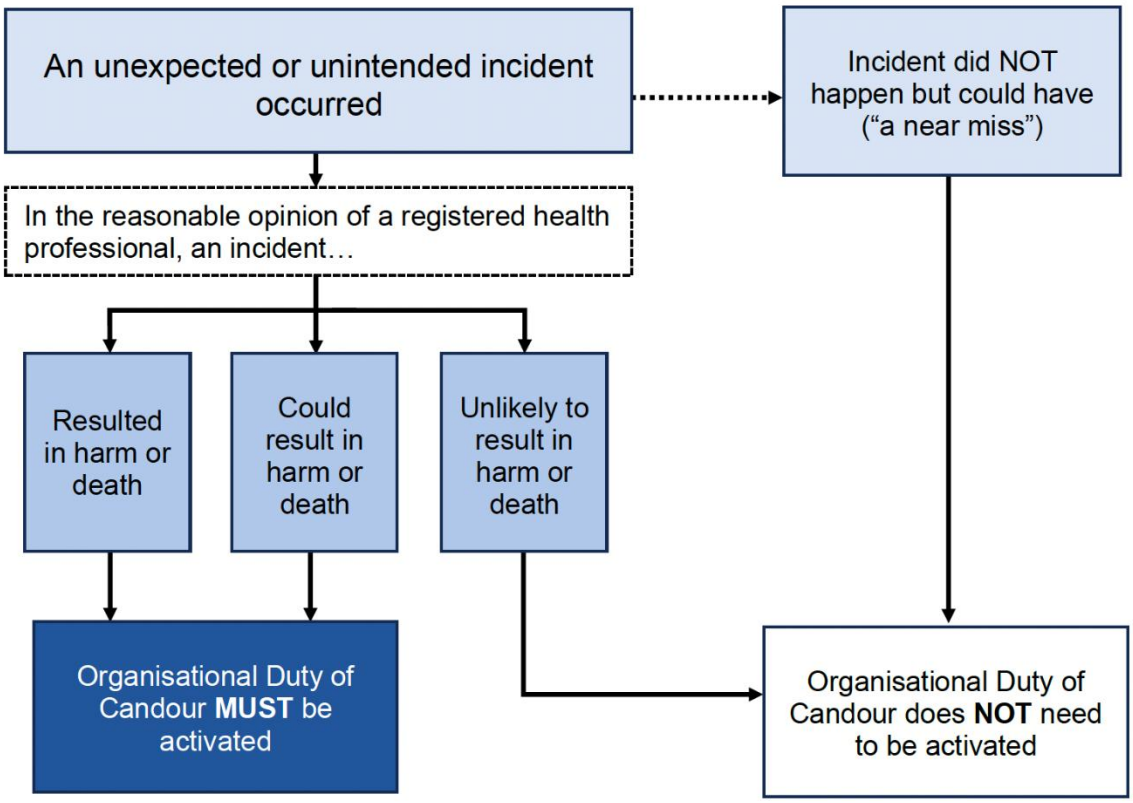
2.5 Harm may not necessarily be severe; however, duty should be assessed in cases involving the following outcomes:

- an increase to a person's treatment
- changes to the structures of their body
- the shortening of life expectancy
- 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 is 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

2.6 When an incident that meets the Duty of Candour definition occurs health and care providers are required to:

- Notify the person affected or their family
- Apologise
- Report
- Review related processes
- Involve the person affected or their family in the process, providing an opportunity to ask questions and offer views
- Provide a written account of the review outcome to the person and/or their family

2.7 The diagram below forms part of the 2025 Guidance, setting out the decision-making process for Duty of Candour.



2.8 The Act sets out that an organisation that provides a health, care, or social work services during a financial year must prepare an annual report. The report must include:

- Information about the number and nature of incidents to which the organisational duty of candour procedure has applied in relation to a health service, a care service, or a social work service provided by the HSCP
- An assessment of the extent to which the organisation completed the necessary steps required by the organisational duty of candour procedure
- Information about any changes to the HSCP's policies and procedures as a result of incidents to which the organisational duty of candour procedure has applied

2.9 The HSCP must notify Healthcare Improvement Scotland, Scottish Ministers, and the Care Inspectorate when the annual report is published.

3. Legal

3.1 Following the Duty of Candour process and offering an apology to an individual and/or family member/carer does not equate to an admission of liability for the HSCP.

3.2 Section 23(1) of The Act defines an "apology" as a statement expressing sorrow or regret concerning an unintended or unexpected incident. The Act clarifies that offering an apology or undertaking any action in accordance with the organisational Duty of Candour procedure, does not constitute an admission of negligence or a breach of statutory duty.

4. Duty of Candour Cases

4.1 Learning Reviews (LR) are commissioned by a Multi-Agency Learning Review Panel on behalf of the Public Protection Committees and Chief Officers Group, following a significant event involving a child(ren) or adult(s) that led to harm or potential for harm. The Learning Review Panel screen cases from a range of providers and services and make recommendations as to whether a review should be undertaken. Whilst cases may be escalated from several services/organisations such as Education, Police Scotland, Scottish Children's Reporter's Administration, Third Sector and NHSGGC Acute Services, a significant proportion involve Social Work Services and therefore Duty of Candour, where applicable, should be considered at the point of referral to the Learning Review Panel and again during the Review.

4.2 However, there is currently no process in place to apply Duty of Candour assessment for social work services. An urgent review of policies will be undertaken by end of 2025 in order that cases can be reported for the following year where social work services are involved with service users who come to harm as described at Section 2.5 above.

4.3 It should be noted that, despite the absence of a formal Duty of Candour process and recording, each review involves service users and/or family members where appropriate, listening to their views and offering an apology, and identifying, sharing and implementing learning to improve services.

4.4 NHS Duty of Candour cases are identified from Datix, the risk management and incident reporting system that records events that could impact patient safety, staff wellbeing and significant property issues. Where patient harm is identified in line with the criteria set out above, consideration is given to the commissioning of a Significant Adverse Event Review (SAER). Duty of Candour is considered both at the point of initial review of the incident and during the SAER investigation.

4.5 It should be noted that, regardless of whether Duty of Candour applies, any death, near miss or significant harm caused to a patient should result in an apology and full involvement of the patient and/or family members. Learning from initial reviews, local learning reviews and SAERs should be shared with patients and/or family members as part of closing the investigation, regardless of whether Duty of Candour is applicable.

4.6 In 2024, 34 SAERs were commissioned or reported, with a total of 9 recorded as Duty of Candour cases. In terms of categories, these include 4 Patient Deaths, 1 Treatment to prevent further Harm, 2 Treatment has increased because of Harm and 2 Structure of body has changed because of Harm.

4.7 The Duty of Candour SAERs were commissioned across a range of services including Alcohol and Drug Recovery Services, Community Mental Health, District Nursing, Mental Health Inpatients, Older People's Mental Health, Community Nursing and Sexual Health Services.

4.8 Learning from the Duty of Candour cases include:

- Need to ensure unallocated cases are reviewed regularly
- Transition arrangements between teams should include oversight and management of risk
- Record keeping standards should be audited regularly and upheld
- Risk assessments should be completed in line with policy standards – timeously, comprehensively and accounting for any changes in presentation or care
- Deficits in training requirements for staff appropriate to role including Risk Assessment, Medications management, Safe identification of patients, Use of Specified Persons,
- Improve Blood Bourne Virus pathways

4.9 Learning has led to a number of service improvements, including:

- 7 Minute Briefings
- Standing Operating Procedure developed in relation to management of unallocated cases, ensuring management oversight and accountability
- Practice Development Nurses and Professional Nurse Leads undertaking regular audit activity
- Learning Needs Analysis with full team to identify knowledge gaps
- Re-establishment of Safety Brief Meetings
- Review of Induction content to include learning from SAERs

5. Next Steps

5.1 A review of the SAER process is underway and will include a review of the process from notification of event to the commissioning of a SAER. This will include a check on Duty of Candour responsibilities however there are no known issues in relation to recording or reporting Duty of Candour cases.

5.2 A Review of social work services critical incident reporting and Learning Review process will be concluded by March 2026 and include consideration as to how Duty of Candor should be enacted, recorded and reported at the earliest opportunity.

5.3 Duty of Candour responsibilities will be included in induction processes for all new staff and existing staff will be reminded to complete the Duty of Candour course available on Turas, developed by NES, Scottish Social Services Council, Care Inspectorate and Healthcare Improvement Scotland.

5.4 Chief Social Work Officer will deliver a session on Duty of Candour responsibilities to the HSCP Senior Management Team.

6. Recommendations

6.1 The IJB Finance, Audit and Scrutiny Committee is asked to:

a) Note the content of the report;
b) Note the draft report to the Scottish Government (Appendix 1); and
c) Note next steps to ensure robust reporting and monitoring

Appendix 1 – Duty of Candour Report from Glasgow City Health and Social Care Partnership to Scottish Government for 2024.

Glasgow City Health and Social Care Partnership
Report on Duty of Candour
2024

Introduction

The statutory Duty of Candour provisions of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018 set out the procedure that organisations providing health services, care services and social work services in Scotland are required by law to follow when there has been an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm). The Duty of Candour (Duty of Candour) legislation became active from 01 April 2018.

Organisations are required to apologise and to meaningfully involve patients and families in a review of what happened. When the review is complete, the organisation should agree any actions required to improve the quality of care, informed by the principles of learning and continuous improvement. They should tell the person who appears to have been harmed (or those acting on their behalf) what those actions are and when they will happen. An important part of this duty is that Glasgow City Health and Social Care Partnership provide an annual report about how the Duty of Candour is implemented in our services.

This report describes how Glasgow City Health and Social Care Partnership has operated the Duty of Candour during 2024. The statutory organisational Duty of Candour has been developed to be in close alignment with the requirements of the professional Duties of Candour.

Duty of Candour means that every health and social care professional must be open and honest with patients and people using their services when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that professionals must:

- tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong
- apologise to the patient (or, where appropriate, the patient's advocate, carer or family)
- offer an appropriate remedy or support to put matters right (if possible)
- explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short- and long-term effects of what has happened.

The organisation records and reviews whenever the patient or family was not informed to ensure Glasgow City Health and Social Care Partnership fully meet the policy principles. Professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns. The legislation requires that Glasgow City Health and Social Care Partnership must also publish a Duty of Candour annual report.

Glasgow City HSCP

Glasgow City Health and Social Care Partnership is the integrated planning and delivery of all community health and social care services on behalf of Glasgow City Council and Greater Glasgow and Clyde NHS. The Partnership is directed by the Glasgow City Integration Joint Board (IJB). Glasgow City Health and Social Care Partnership provide services for Children, Adults and Older People, along with Homelessness and Criminal Justice services.

The Partnership comprises of around 12,000 Social Work (Glasgow City Council) and Health (NHS Greater Glasgow and Clyde) staff. It is led by an integrated Executive Leadership and Senior Management Team, and it provides services through the three localities of North East, North West and South and directly provided day, home and residential care. Services are also delivered through Health and Social Care contractors and providers. Some services cover the wider NHS Greater Glasgow and Clyde Health Board area (for example, sexual health services and specialist mental health services).

Glasgow HSCP Duty of Candour Compliance

A total of 9 cases were identified from 2024. Apologies and family engagement was undertaken in all cases.

All cases were subject to a Serious Adverse Event Review (SAER) where actions are identified for improvements, actions are then monitored for implementation. SAERS remain open until all actions have been completed satisfactorily.

GCHSCP staff access training via NHS Education Scotland (NES), training platform, Turas and the NHS training platform LearnPro.

Table 1 Duty of Candour Incidents 2024

	Number of Times an incident has happened
Type of Unexpected or Unintended Incident	
Someone has died	4
Someone has permanently less bodily, sensory, motor, physiologic or intellectual functions	
Someone's treatment has increased because of harm	2
The structure of someone's body changes because of harm	2
Someone's life expectancy becomes shorter because of harm	
Someone's sensory, motor or intellectual functions is impaired for 28 days or more	
Someone experienced pain or psychological harm for 28 days or more	
A person needed health treatment in order to prevent them dying	1
A person needing health treatment in order to prevent other injuries	
Total	9
Was Duty of Candour followed	Yes – in all cases

Improvements Implemented as a Result of Duty of Candour

Various improvements were implemented as a result of Duty of Candour SAERs including:

- Development of 7 Minute Briefings for staff
- Standing Operating Procedure developed and/or reviewed in relation to management of unallocated cases, ensuring management oversight and accountability
- Practice Development Nurses and Professional Nurse Leads undertaking regular audit activity in relation to recording practices, care planning activity and safe interventions
- Learning Needs Analysis with a full team to identify knowledge gaps
- Re-establishment of Safety Brief Meetings for Community Nursing teams
- Review of Induction content for all new staff to include workforce learning identified in SAERs