NHS National Services Scotland Duty of Candour Annual Report 2018 to 2019

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1. Introduction

All health and social care services in Scotland have a duty of candour. 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 duty of candour is implemented in our services. This short report describes how NHS National Services Scotland has operated the duty of candour during the time between 1 April 2018 and 31 March 2019. We hope you find this report useful.

2. NHS National Services Scotland

NHS National Services Scotland (NSS) is a national NHS Board operating across NHHSScotland. Through our services we provide invaluable support and advice. This is a role which extends to the wider public sector.

NSS supports customers to deliver their services more efficiently and effectively. We offer shared services on a national scale using best-in-class systems and standards. Our aim is to help our customers save money and free up resources so they can be re-invested into essential services. We also provide consultancy and support to help public bodies join up health and social care. Our priority is to support Scotland's health. We do this by offering whatever's needed, whenever and wherever it's needed and to whoever needs it.

NSS is made up of six strategic business units:

- Central Legal Office
- Digital and Security
- Practitioner and Counter Fraud Services
- Procurement, Commissioning and Facilities
- Public Health and Intelligence
- Scottish National Blood Transfusion Service

Four supporting business units and corporate directorates:

- Clinical
- Finance
- Human Resources and Workforce Development
- Strategy, Performance and Service Transformation

It must be noted that NSS has a limited number of services which are patient facing, and is more usually in a role as a support organisation or in a sharing responsibility for delivery of services, which are not necessarily frontline.

3. How many incidents happened to which the duty of candour applies?

Between 1 April 2018 and 31 March 2019, there were three incidents where the duty of candour applied. These are unintended or unexpected incidents that result in death or harm as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition.

NHS National Services Scotland identified these incidents through our adverse event management process. All adverse events are subject to a review, which includes a wider range of outcomes than those defined in the duty of candour legislation. This means that events that did not result in significant harm but had the potential to cause significant harm may, in some cases, require a higher level of review.

We identify through the adverse event review process if there were factors that may have caused or contributed to the event, which helps to identify duty of candour incidents.

Table 1: Total number of incidents by type

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 2018 and 31 March 2019)**
A person died	
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	
A person's treatment increased	2
The structure of a person's body changed	
A person's life expectancy shortened	
A person's sensory, motor or intellectual functions was impaired for 28 days or more	
A person experienced pain or psychological harm for 28 days or more	
A person needed health treatment in order to prevent them dying	
A person needing health treatment in order to prevent other injuries as listed above	1
Total	**3**

4. To what extent did NHS National Services Scotland follow the duty of candour procedure?

When the events concerned were identified, the correct procedure was followed in three out of the three occasions (100% of the time). In each case the people affected were informed, an apology was offered along with an offer to meet with NSS colleagues. In each case, a full review was carried out and mitigating actions and lessons learned identified.

5. Information about our policies and procedures

Every adverse event is reported through our local reporting system as set out in our adverse event management policy. Through our adverse event management process we can identify incidents that trigger the duty of candour procedure. Our adverse event management policy contains a section on implementing the duty of candour.

Each adverse event is reviewed to understand what happened and how we might improve the care we provide in the future. The level of review depends on the severity of the event as well as the potential for learning.

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

All relevant staff receive training on adverse event management and implementation of the duty of candour, so that they understand when it applies and how to trigger the duty. The duty of candour elearning module is now mandatory for all NSS clinical colleagues and we will be developing face-to-face training for senior colleagues based on the NES duty of candour training pack when it is finalised.

We know that adverse events can be distressing for staff as well as people who receive care. We have support available for all staff through our line management structure as well as through occupational health.

6. What has changed as a result?

We have made a number of changes following review of the duty of candour events that we wish to highlight.

- Two duty of candour events related to one particular type of procedure. The events involved machinery and items supplied by an external company, therefore the Incident Reporting and Investigation Centre (IRIC) were

informed to ensure that the events were considered independently. IRIC will monitor for any similar events.

- Operator error was thought to have been a factor in both of these events. SBARs were compiled following each event and shared with relevant staff to raise awareness of the event and the potential for operator error. Staff were reminded that in line with good practice similar types of incidents that may occur must always be reported. Staff were also issued with a training information sheet to reinforce procedure.
- Following review of the first of these events, there was a change in practice and this was reflected in an updated standard operating procedure accessible to all staff.
- The Scottish National Blood Transfusion Service (SNBTS) has reviewed patient and donor leaflets and agreed that where appropriate a statement relating to duty of candour will be added to each type of leaflet when they are due for review or reprint.
- In April 2019, a meeting was held with senior leads to reflect on the adverse events management policy and process as well as duty of candour. It was identified that a clearer escalation process and governance structure needed to be documented particularly around duty of candour. A full revision of the NSS Adverse Events Management Policy 2018 will not take place until the Healthcare Improvement Scotland national adverse event framework review is complete however interim changes can be made relating to duty of candour including an escalation flowchart.

7. Other information

This is the first year of the duty of candour being in operation and it has been a year of learning and refining our existing adverse event management processes to include the duty of candour outcomes.

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

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