NHS National Services Scotland
Duty of Candour Annual Report
2019 to 2020

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1 Introduction

All health and social care services in Scotland have an organisational 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. The procedure to be followed is set out in the Duty of Candour Procedure (Scotland) Regulations 2018.

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 report describes how we have operated the duty of candour during the time between 1 April 2019 and 31 March 2020.

2 About NHS National Services Scotland

NHS National Services Scotland (NSS) is a national NHS Board operating across NHSScotland. We provide invaluable support and advice. This is a role which encompasses the wider public sector.

NSS supports the delivery of safe, effective and efficient health and social care throughout Scotland. We offer shared services on a national scale using best-in-class systems and standards. Our aim is to help our customers optimise their services to ensure best use of resources. We also provide consultancy and support to help public bodies join up health and social care. Our priority is always to support Scotland's health and social care. We do this by offering whatever is 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[1]
- Scottish National Blood Transfusion Service (SNBTS)

[1] On 1 April 2020 the Public Health and Intelligence Strategic Business Unit transferred to Public Health Scotland and is no longer part of NHS National Services Scotland

Four supporting business units and corporate directorates:

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

3 Information about our policies and procedures

All adverse events are reported and reviewed using two local reporting systems (Q-Pulse) as set out in our NSS Adverse Events Management Policy and associated guidance. Through our adverse events management process, we can identify events that trigger the organisational duty of candour procedure.

Each adverse event is reviewed to understand what happened and how we might learn from, and improve the care and services we provide in the future. The level of review depends on the severity of the adverse 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. In NSS, monitoring of adverse event reporting takes place via the information governance and clinical governance frameworks.

All staff must complete a mandatory information governance e-learning module, which includes adverse event reporting. Additional training is available on request for staff involved in reviewing adverse events on Q-Pulse, so that they understand when it applies and how to trigger the duty. The national duty of candour e-learning module was available to staff during the reporting period and it was agreed via the clinical governance framework that it should be a mandatory requirement for all registered healthcare professionals contracted to NSS to complete. Monitoring and reporting our compliance with the module remained in progress during the reporting period.

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, occupational health referral process as well as guidance on accessing employee assistance and counselling.

4 How many adverse events happened to which the duty of candour applies?

NSS has few services which are patient facing, and is more usually in the role of a support organisation or in a sharing responsibility for delivery of services which are not necessarily frontline for example screening, including Breast, Bowel and Cervical. We therefore look carefully at all adverse events in order to determine if the principles of Duty of Candour apply.

Between 1 April 2019 and 31 March 2020, there was one clinical adverse event, which was fully investigated and confirmed that the organisational duty of candour applied. This unintended or unexpected incident resulted in death or harm as defined in the Act, and did not relate directly to the natural course of someone's illness or underlying condition.

NHS National Services Scotland identified this event through our adverse event management process. All adverse events are subject to a level of 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 2019 and 31 March 2020)**
A person died	
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	
A person's treatment increased	
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	**1**

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

When the adverse event concerned was identified, the correct procedure was followed. A review was carried out to understand what happened, what went wrong and what learning could be taken forward for the future. The person affected received a verbal apology during an initial telephone contact followed by a formal letter of apology. However, they were not involved any further in the duty of candour procedure after a number of unsuccessful attempts were made by the donor medical team to contact them. Improvement actions were put in place and the event was then closed.

6 What has changed as a result?

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

- The event related to a serious adverse event of donation. It was concluded that a not unknown complication of cannulation was not recognised at session, this resulted in a need for medical intervention. In response to the event, further detail has been added to the standing operating procedure around the management and follow up of cannulation. It is now stated that donors with a history suggestive of complications of cannulation or venepuncture or with confirmed complication should be advised to see their GP (or NHS 24 or accident and emergency, if out of hours) and contact SNBTS if they develop worsening or new symptoms.
- SNBTS Donor Services has reviewed its venepuncture training materials to improve staff knowledge, recognition and management of complications. A group has been formed to review the new teaching materials and consider strategies to further improve venepuncture performance and the recognition and management of adverse events at donor sessions.
- The NSS Clinical Governance and Quality Improvement framework and three-year work plan was approved by the Clinical Governance Committee in December 2019. The work plan includes required actions around the organisational duty of candour governance arrangements and process in NSS. In the reporting period we developed:
    - a bespoke face-to-face training pack for relevant staff
    - an improved NSS internal process for activation and escalation of duty of candour
    - a standard operating procedure for SNBTS staff
- The staff training programme was due to be rolled out during March 2020 however had to be put on hold due to conflicting priorities of the Covid-19 response and is set to commence in September 2020. Monitoring and compliance with training will be considered during 2020 and 2021.

7 Other information

This report is disseminated via the clinical governance framework for internal information prior to final approval by the Board. As required, we have submitted this report to Scottish Ministers and we have also placed it on our website.

If you would like more information about this report, please contact us using these details:

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