NHS National Services Scotland

Duty of Candour Annual Report

April 2022 to March 2023

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 organisational duty of candour during the time between 1 April 2022 and 31 March 2023.

About NHS National Services Scotland

NHS National Services Scotland (NSS) is a national NHS Board operating right at the heart of 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 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.

By connecting with partners, stakeholders in other public bodies and the people of Scotland, we can use our national position to ensure our services, solutions and programmes of work are aligned to, coordinated with, and enable regional and local activities.

NSS is made up of seven Directorates:

- Central Legal Office
- Digital and Security
- National Procurement
- National Services Division
- NHS Scotland Assure
- Practitioner and Counter Fraud Services
- Scottish National Blood Transfusion Service

And four corporate services:

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

Number and nature of duty of candour incidents

In the last year, how many incidents did the duty of candour procedure apply?

NSS provides few services which are public facing, outside of the Scottish National Blood Transfusion Service (SNBTS) (patient services and donor services). We are usually in the role of a support organisation, or share responsibility for delivery of services, which are not necessarily frontline, such as Abdominal Aortic Aneurysm, Breast, Bowel, Cervical and Pregnancy and Newborn Hearing Screening Programmes. NSS also provides substantial digital support services. Due to the diverse nature of our services, we therefore look carefully at all adverse events to determine if the principles of duty of candour apply.

Between 1 April 2022 and 31 March 2023, there was one adverse event where the duty of candour applied. This event, as defined in the Act, did not relate directly to the natural course of the person's illness or underlying condition or with the healthcare service they received.

This adverse event was first identified following review of a complaint. The adverse event was raised, reviewed and the duty of candour applied. The event is subject to a review using the adverse event management process.

It is noted, that beyond the duty applied within the act, we apply the principles of open, honest and transparent communication when reviewing adverse events. This means that although the formal duty of candour may not be applied, we still invoke the "spirit" of the Act when communicating with patients, donors and their families. These events include a wider range of outcomes than those defined in the duty of candour legislation as we also include adverse events that did not result in significant harm but had the potential to do so.

When carrying out the adverse event review process, the criteria listed below are considered to support the decision-making on whether any of these have caused or contributed to the adverse event, which can then identify if these are duty of candour events or not.

Table 1: Nature of unexpected or unintended incident where Duty of Candour applies

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died	0
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	0
Changes to the structure of the person's body	0
The shortening of the life expectancy of the person	0
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	0
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.	1
The person required treatment by a registered health professional in order to prevent:	
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

To what extent did NHS National Services Scotland carry out the duty of candour procedure?

SNBTS followed the documented procedure for managing adverse events and the duty of candour procedure. This means we informed the person affected, apologised to them, and offered to meet with them. We reviewed what happened and what went wrong to try to learn for the future.

The person received a formal letter of apology. We offered to meet with them however this has not yet been accepted by the person. A formal review meeting has taken place with staff involved in the adverse event and a letter summarising this meeting has been formally sent by the lead contact to the person. We offered to send the person a final copy of the review report.

Information about our policies and procedures

What processes are in place to identify and report unexpected or unintended incidents that may require activation of the duty of candour procedure?

Adverse events and near misses (except for SNBTS quality related incidents) are reported using our local reporting system called ServiceNow, as set out in the NSS Adverse Event Management Policy and associated procedure. These include further information and guidance on implementing the duty of candour.

SNBTS report all quality related incidents and deviations from accepted practice within their own quality management system called Q-Pulse. Q-Pulse is used to record these in compliance with their regulatory and accreditation requirements. There is SNBTS specific policy and guidance, which includes information on duty of candour, such as the SNBTS Quality Related Incident Policy and guidance on reporting of blood donor adverse events.

In January 2021, SNBTS implemented the SNBTS duty of candour standing operating procedure (SOP). This is to aid staff to identify unintended or unexpected incidents including examples of situations specific to SNBTS services where the duty of candour may apply. All SNBTS guidance aligns with the NSS-wide adverse event management policy and procedure.

In addition to NSS policy and guidance, we also refer to the duty of candour guidance and FAQs published by Scottish Government to aid with the decision-making.

When a possible duty of candour event is identified, there is discussion between clinicians, duty of candour leads and partner agencies (including other health boards), where appropriate, and clinical governance groups. Due to the complexity of our services, such as screening programmes, we must also always consider duty of candour in its widest sense to include Public Health.

What criteria do you use to assess whether the duty of candour procedure should be activated?

Each adverse event is recorded in ServiceNow or Q-Pulse (SNBTS). The level of review applied depends on the severity of the event as well as the potential for learning. We review these events to understand what happened and how we might learn from and improve the care and services we provide in the future. For all events which meet the criteria for duty of candour, these are subject to a more formal review. Recommendations are made as part of the adverse event review and local teams develop improvement plans to meet these. Monitoring of plans takes place within teams and completion of actions tracked using ServiceNow or Q-Pulse (SNBTS). SNBTS developed an additional form to capture details of the duty of candour process which is attached to the system record.

Reporting on adverse events, including duty of candour, takes place through NSS clinical governance structure. Regular reporting on duty of candour events take place at Directorate-level clinical governance groups, which meet monthly or quarterly. Corporate oversight is provided by the NSS Clinical Governance and Quality Improvement Group, which meets monthly. Reporting arrangements to provide Board-level assurance take place through the NSS Clinical Governance and Quality Improvement Committee.

What support is available to staff who are involved in unintended or unexpected incidents resulting or could result in harm or death?

Staff have access to information on the NSS intranet via our adverse event management and duty of candour pages. Staff are encouraged to complete the national duty of candour e-learning module. All staff must complete a mandatory information governance e-learning module, which includes a section on how to identify and report an adverse event. Additional training is available on request for staff involved in adverse event reviews.

SNBTS staff must receive Q-Pulse training before they can access the system due to the strict legal requirements.

NSS has a commitment to all staff who are involved in an adverse event to ensure that they are offered support at a time and in a way that meets their needs. Staff involved in an adverse event may be physically and / or psychologically affected by what has happened. Line managers have a responsibility to check in with their staff and help to identify appropriate support for individuals and teams. This may include protected time for a staff member to prepare information as part of an adverse event/ duty of candour review, referral to occupational health or advice around counselling services and / or contact with their staff side representatives

What support is available to relevant persons who are affected by unintended or unexpected incidents resulting or could result in harm or death?

NSS will provide information and support to donors, patients, participants or families if they are affected by an adverse event where the organisational duty of candour is applied. Compassion and understanding should always be demonstrated, and arrangements made for regular contact to keep people involved and informed. This will include:

- acknowledgement of the possible distress that the adverse event has caused
- a factual explanation of what has happened (as much as is known at the time), including a formal apology
- a clear statement of what is going to happen next as part of the Duty of Candour procedure
- any action which can be taken in the interim to resolve the adverse event
- a named contact

What changes, learning and/or improvements to services and patient outcomes can you identify as a result of activating the duty of candour procedure and the required reviews that have taken place?

NSS has a very small number of duty of candour events. Due to the small number and the highly specialised services provided, every care is taken to ensure absolute anonymity for those involved. Therefore, details of specific interventions and events have been removed and high-level learning included as opposed to operational changes in procedures and practice. Following review, improvements to our services have been implemented:

- A change in local operating/reporting procedure has been implemented to ensure more swift escalation of potential issues with procedures and staff training adjusted to reflect this.

What improvements/ changes, if any, have been made to the approach to considering and implementing the duty of candour process itself, as a result of activating the procedure?

The discussion and decision-making forum around duty of candour has continued to mature during the year. Potential events are considered at an early stage by a wide group of clinicians with a more rounded and informed approach to duty of candour being applied.

Other information

This report is shared with the relevant duty of candour leads for accuracy before submitting through the NSS clinical governance structure culminating in final approval by the Board. As required, we have notified the Scottish Government that this report is complete and accessible on the NSS website.

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

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