NHS National Services Scotland

Duty of Candour Annual Report April 2023 to March 2024

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Produced by: Clinical Directorate

Contents

Introduction

All health and social care services in Scotland have a duty of candour. This is a legal requirement which means that when things go wrong and mistakes happen, the people affected understand what has happened, receive an apology, and the organisation can learn how to improve for the future.

Organisations must publish an annual report about the duty of candour in our services. This short report describes how NHS National Services Scotland has operated the duty of candour during the time between 1 April 2023 and 31 March 2024. We hope you find this report informative.

If you have any questions or would like more information about NHS National Services Scotland, please feel free to contact us at: nss.feedback@nhs.scot.

About NHS National Services Scotland

NHS National Services Scotland (NSS) was established to provide services that were common to all health boards in Scotland. NSS started operating as the Common Services Agency in 1974 under The National Health Service (Functions of the Common Services Agency) (Scotland) Order 1974, with a mandate to provide national strategic support services and expert advice to Scotland's health sector whilst maximising health impacts and cost savings.

In 2013, the Public Services Reform (Functions of the Common Services Agency for the Scottish Health Service) (Scotland) Order 2013 extended the remit of NSS enabling the provision of services to other bodies, including local authorities and government departments.

The following year, the Public Bodies (Joint Working) Scotland Act 2014 reinforced this requirement to maximise health, financial and environmental impacts by engaging with, and offering services, to the wider public sector in Scotland.

Today, we provide a wide range of national services and manage one-third of the NHSScotland budget. Our purpose is to provide national solutions to improve the health and wellbeing of Scotland.

Information about our policies and procedures

Adverse events and near misses, with the exception of Scottish National Blood Transfusion Service (SNBTS) quality related incidents, are reported using our local reporting system called ServiceNow. This is set out in the NSS Adverse Event Management Policy and associated procedure. These include further information and guidance on implementing the duty of candour. Where something has happened that triggers an adverse event where duty of candour may apply, staff should contact their senior manager or senior clinician. The NSS clinical governance team should also be notified within 72 hours where duty of candour has been applied.

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). The SOP was revised in July 2023. It helps staff to identify when the duty of candour may apply following an unintended or unexpected incident. It includes examples of situations specific to SNBTS services where the duty of candour may apply. Where something has happened which may trigger the duty of candour, staff should contact the SNBTS duty of candour leads who have responsibility for ensuring that the duty of candour procedure is followed. 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, 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.

Each adverse event is recorded in ServiceNow or Q-Pulse. The level of review applied depends on the severity of the event. However, all events have a focus on 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. When an event meets the criteria for duty of candour, it is subject to a more formal review. Recommendations are made as part of all adverse event reviews 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 developed an additional form to capture details of the duty of candour process which is attached to the Q-Pulse record.

Reporting on adverse events, including duty of candour, takes place through the NSS clinical governance structure. Regular reporting on duty of candour events takes 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 Committee.

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 or duty of candour review, referral to occupational health or advice around counselling services and / or contact with their staff side representatives.

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 taken in the interim to resolve the adverse event
- a named contact

How many incidents have occurred where the Duty of Candour has applied?

NSS provides few services which are public facing, outside of 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 frontline for NSS, 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 2023 and 31 March 2024, there was one adverse event where the duty of candour applied. There was a known complication of blood donation which was not identified at the time of donation. The adverse event was identified later when notified by the person concerned. An adverse event was raised, and the duty of candour applied. It is subject to 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 all 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 cause significant harm.

Type of unexpected or unintended incident	Number of times this happened
Someone has died	0
Someone has permanently less bodily, sensory, motor, physiologic or intellectual functions	0
Someone's treatment has increased because of harm	0
The structure of someone's body changes because of harm	0
Someone's life expectancy becomes shorter because of harm	0
Someone's sensory, motor or intellectual functions is impaired for 28 days or more	0
Someone experienced pain or psychological harm for 28 days or more	1
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries	0
A person caught a preventable healthcare acquired infection (HCAI) during their treatment	0

To what extent did NHS National Services Scotland follow the Organisational Duty of Candour procedure?

We did not follow the procedure fully in this instance. We informed the person affected, apologised, and offered to meet. The person received a formal letter of apology. Unfortunately, there was a delay in the meeting taking place.

What has changed as a result? / What have we learnt?

We will revise and refresh our duty of candour training and implement role specific training across areas of NSS.

Other Information

This is the fifth year of the organisational duty of candour being in operation and it has been a learning experience for our organisation. In SNBTS, we are confident that the organisational duty of candour procedure is well embedded within the directorate. The duty is considered by staff following any adverse event which occurs and will be discussed with other relevant staff and duty of candour leads. The number of adverse events where the duty of candour has been applied is consistent with previous years.

As required by the duty, we have submitted this report to Scottish Ministers. In order that our report is as accessible as possible, we have published this on the NSS website.