NHS National Services Scotland

Duty of Candour Annual Report April 2021 to March 2022

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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 2021 and 31 March 2022.

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 five strategic business units (SBU):

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

Four supporting business units and corporate directorates:

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

Number and nature of duty of candour incidents

In the last year, how many adverse events did the duty of candour 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 in a sharing responsibility for delivery of services, which are not necessarily frontline, such as Abdominal Aortic Aneurysm, Breast, Bowel, and Newborn 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 2021 and 31 March 2022, there were six clinical adverse events where the Duty of Candour applied. These unintended or unexpected events that 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.

NSS identified these events through our adverse event management process. All adverse events are subject to a level of review, which 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 the Duty of Candour procedure should be activated.

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	2
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	3
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?

When we realised the events listed above had happened, we followed the correct procedure in all six occasions. This means we informed the people affected, apologised to them, and offered to meet with them. In each case, we reviewed what happened and what went wrong to try and learn for the future.

Each person affected received a formal letter of apology. Of the six cases where we offered to meet with the patient, donor, or their family, three did not respond to our invitation. In one case, the individual requested a face-to-face meeting, which took longer to arrange, but was held via Microsoft Teams due to self-isolation guidance.

Table 2: Number of cases and compliance with duty of candour procedure

Stage	Number
Patient or donor or their family informed	6 (100%)
Letter of apology sent	6 (100%)
Meeting offered	6 (100%)

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 application called ServiceNow as set out in our adverse event management policy and associated procedure. Through our adverse event management process, we identify events that activate the Duty of Candour procedure. Adverse events are sometimes picked up through our complaints process. Our adverse event management policy and associated procedure contain guidance on activating the organisational Duty of Candour.

SNBTS report all quality related incidents and deviations from accepted practice within their own quality management system. The application, Q-Pulse, is used to record these in compliance with their regulatory and accreditation requirements. SNBTS quality related incident policy and associated guidance include information on Duty of Candour. SNBTS guidance on reporting of blood donor adverse events also includes early consideration of Duty of Candour. SNBTS Duty of Candour standing operating procedure (SOP) aids 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 adverse event management policy and procedure.

Each adverse event is recorded, and 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. However, beyond the Duty applied within the Act, we apply the principles of open, honest and transparent communication when reviewing clinical events and incidents. This means that although an event may not trigger the formal Duty of Candour, we still invoke the “spirit” of the Act when communicating with patients, donors and their families.

Recommendations are made as part of all adverse event reviews and local teams develop improvement plans to meet these. Duty of Candour cases are subject to a more formal review. Monitoring of plans takes place within teams and completion of actions tracked using the ServiceNow and Q-Pulse systems. Clinical adverse events, including events where Duty of Candour has been activated, are reported through the NSS clinical governance reporting structure. SBU governance groups meet monthly as does the Clinical Governance and Quality Improvement Group where there is corporate oversight of clinical adverse events, including Duty of Candour. Reporting arrangements are in place for providing assurance on clinical adverse events, including Duty of Candour, to the Clinical Governance and Quality Improvement Committee.

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. A planned roll out of bespoke Duty of Candour training with SNBTS staff was commenced but due to Covid restrictions and workload training sessions were less than anticipated.

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

In addition to our adverse event management policy and procedure, and SNBTS-specific guidance, we refer to the Duty of Candour guidance and FAQs by Scottish Government. When a possible Duty of Candour event is identified, there is discussion between clinicians and nominated Duty of Candour leads in the organisation and partner agencies, where appropriate. Due to the complexity of our services, such as screening programmes, we must always consider Duty of Candour in its widest sense to include Public Health.

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

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
- 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. In particular, the donor information booklet and patient information leaflet on receiving a transfusion have been updated to include a section on Duty of Candour. The SNBTS website called Scotblood includes information for donors on following the Duty of Candour legislation if there is an unintended or unexpected complication of donation.

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. Some examples of these are highlighted below:

- Improvements to the labelling of some blood components issued from SNBTS
- Updates to SOPs relating to the operation of controlled rate freezer units
- Reviewed our processes to ensure robust communications to staff of updates to donor selection guidance
- Agreed to deliver adverse events training as part of SNBTS staff mandatory training. This will include information about exploring the cause of donors feeling faint.
- Updated our donor and patient information leaflets and Scotblood website to include information on Duty of Candour

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?

We have made a few changes following review of the Duty of Candour events that we wish to highlight.

- Updated the SNBTS Duty of Candour SOP with examples of situations specific to SNBTS services where the Duty of Candour may apply
- Reviewed our adverse event management policy and separated the operational elements into an associated procedure. This allowed for a more manageable and detailed guidance document for staff around the stages of adverse event management, including consideration of Duty of Candour

Covid-19 Pandemic

Setting the context

What processes were put in place to manage the impact of Covid-19 when activating the duty of candour procedure?

NSS are confident that the processes already in place were adequate to manage the very small number of Duty of Candour events activated within our board.

Did the timeframe in which it took to review cases increase due to the ongoing pressures of dealing with Covid-19? If so, by how much?

COVID-19 did not affect the response time for any Duty of Candour events.

How many or what percentage of the times when the duty of candour procedure was activated this year have been directly attributable to Covid-19?

No adverse events where the organisational Duty of Candour was activated were directly attributable to Covid-19.

Practical Actions Taken

How has involving the relevant person been impacted by Covid-19? For example, involving relevant persons in review meetings and continuing communication.

There continued to be limitations on face-to-face engagement during 2021-22 however, communications took place by telephone and via Microsoft Teams.

In light of the Covid-19 pandemic, what adjustments have you made to continue to involve relevant persons as required by the duty of candour procedure?

Communications have taken place by telephone or via Microsoft Teams where necessary.

The duty of candour procedure provisions reflect the Scottish Government's commitment to place people at the heart of health and social care services in Scotland. In light of this and the Covid-19 pandemic, how did you ensure a person-centred approach was maintained when the decision was made to activate the duty of candour procedure?

An open, transparent and person-centred approach has been maintained for all six events which activated the Duty of Candour procedure. We are confident that our processes and procedures reflected this approach.

Learning for the future

Responding to the Covid-19 pandemic will have meant changes to NHS National Services Scotland's policies and processes, including activating the duty of candour procedure for unintended or unexpected incidents resulting or could result in harm or death.

Duty of Candour Procedure

What changes, if any, to the way you consider and implement the duty of candour procedure will you continue with as the Covid-19 pandemic continues?

The improvements made in NSS to how we implement the Duty of Candour procedure remain ongoing as part of our clinical governance and quality improvement framework.

What difficulties have you encountered when reviewing unintended or unexpected incidents due to Covid-19? What learning can be taken away from these particular difficulties?

NSS did not encounter difficulties when reviewing of any events due to Covid-19.

Provision of Healthcare Services

Has there been specific learning from activating the duty of candour procedure to unintended or unexpected incidents which have resulted in or could have resulted in harm and death which are directly linked to the Covid-19 response? If so, what has this learning been?

No adverse events where the organisational Duty of Candour was activated were directly linked to the Covid-19 response.

What other learning have you been able to identify as a result of applying the duty of candour procedure?

Any learning identified where applying the Duty of Candour procedure has been in line with our current procedures and not related to Covid-19 or its response.

Additional Information

Please provide any further information you think might be important or relevant. For example, ways in which discussion, decision-making and reviews linked with the duty of candour procedure have supported continuous improvements in delivering safe, effective and person-centred care?

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

The clinical governance and quality improvement team disseminates this report using the clinical governance reporting arrangements for internal information prior to final approval by the Board. As required, we have notified the Scottish Government that this report is complete and accessible on the NSS website.

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