NHS National Services Scotland

Duty of Candour Annual Report
April 2024 to March 2025

June 2025

Contents

Introduction

All health and social care services in Scotland have an organisational duty of candour. This is a legal requirement which means that when certain types of incidents happen, the people affected understand what has happened, receive an apology, and the organisation learns how to improve for the future. Openness and honesty are central to the actions of healthcare organisations in maintaining trust and effective communication when there has been unintended or unexpected harm.

An important part of this duty is that we provide an annual report about the organisational duty of candour process in our services and the events that have triggered their use. This report describes how NHS National Services Scotland (NSS) has operated the organisational duty of candour process during the period between 1 April 2024 and 31 March 2025.

If you have any questions or would like more information about NHS NSS in relation to this report, please contact nss.feedback@nhs.scot.

About NHS National Services Scotland

NHS NSS started operating as the Common Services Agency in1974, because of The National Health Service (Functions of the Common Services Agency) Order 1974. Our mandate is to provide national strategic support services and expert advice to Scotland's health sector whilst maximising health impact 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 reinforced this requirement to maximise health, financial and environmental impact 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

In NSS we use the term adverse event to describe when something has happened that has caused harm to a person, groups of people or the organisation. How we report, record and manage adverse events is detailed within our Adverse Event Management Policy and associated procedure. The procedure informs staff to contact their line manager when an event has happened which may activate the organisational duty of candour.

Within NSS, the Scottish National Blood Transfusion Service (SNBTS) has specific policies and guidance, such as the SNBTS policy for the Reporting and Management of Quality Related Incidents and guidance on reporting of blood donor adverse events. An SNBTS specific organisational duty of candour standing operating procedure, which has been reviewed and updated this year, helps staff who work in this part of NSS services, to identify when the organisational duty of candour may apply and instructs them to contact their senior clinical lead on duty.

When a possible organisational duty of candour incident is identified, there is discussion between clinicians, duty of candour leads, the clinical governance team, information governance (in the case of a data breach) and partner agencies (including other health boards), where appropriate. Due to the complexity of our services, such as national screening programmes or national IT systems, we must also always consider duty of candour in its widest sense to include Public Health.

All adverse events are subject to review. It may not be clear at the time an adverse event occurs whether it meets the legally defined threshold for organisational duty of candour criteria and may only become apparent as an outcome from an adverse event being reviewed, or when a clinical concern is raised later. As soon as the review recognises that the level of harm has met the threshold, the organisational duty of candour process is enacted. Reviews always focus on learning to understand what happened and how we might improve the care and services we provide in the future. Following a review, the team involved will develop an improvement plan with actions tracked and the learning shared.

Reporting on adverse events, including where duty of candour has been applied, happens through the NSS clinical governance structure. Directorate-level teams and their wider directorate clinical governance groups 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.

Training and Support for Staff

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 may be physically 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 a staff member, such as protected time to prepare for a review, referral to occupational health, advice around counselling services and / or contact with their staff side representatives. There is an internal occupational health and wellbeing portal which provides further information links, signposting and guidance for both staff and Line Managers.

Support for the Relevant Person

In all cases, where an adverse event occurs there is a professional duty of candour for the clinician involved to advise a person that something has gone wrong, or an error has occurred, apologise, and take any immediate action to address any safety concerns and support the person affected.

When the relevant person and their family / support system are affected by an adverse event that activates the organisational duty of candour, we will arrange for regular contact to keep them involved and informed. Compassion and understanding should always be demonstrated. In SNBTS, donors may be provided with information leaflets if there has been an issue during their donation. For example, they will be provided with a nerve injury leaflet and follow up by a member of the medical team if there has been any disproportionate pain during their donation.

How many incidents have occurred where the organisational duty of candour has applied?

NSS provides few services which are public facing, outside of SNBTS patient services and donor services. SNBTS currently has 96,872 active donors. We are usually in the role of support organisation or share responsibility for the delivery of

services (which are not frontline for NSS) such as abdominal aortic aneurysm, bowel, breast, and cervical 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 organisational duty of candour apply.

In the last year, there was one event to which the organisational duty of candour applied. This related to a donor suffering arm pain following a blood donation. A review identified that appropriate follow up with the donor medical team had not been arranged and this had potentially contributed to the donor's symptoms. The arm pain lasted for a prolonged period meeting the organisational duty of candour threshold (see table 1).

Table 1 – Type of event triggering organisational duty of candour

Type of unexpected or unintended event	Number of instances
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 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 to prevent them dying	0
A person needing health treatment to prevent other injuries	0
A healthcare infection incident was acquired during treatment	0

To what extent did NSS follow the organisational duty of candour procedure?

We followed the procedure fully. This means:

- we informed the person affected, provided a written apology, and met with them to explain what had happened, how we had investigated and shared the learning we would use to improve our services.

- we also listened to their views and acted on their concerns.
- internally, senior staff reflected on the events and identified where systems went wrong and how we could do better
- this organisational learning was shared with relevant staff through the staff safety brief

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

As a result of learning from this event, which activated the organisational duty of candour, there has been focused staff training to ensure appropriate clinical follow up for donors is in line with the policies and processes in place. Work within donor services to prioritise improved training on informed consent, adverse events and duty of candour has been completed with a duty of candour report template updated to emphasise key learning and actions for improvement.

Other information

As required in legislation, we have notified Scottish Ministers that the report has been published on the NHS National Services Scotland website.

The organisational duty of candour lead in NSS is our Executive Medical Director, Sharon Hilton-Christie.