

**Duty of Candour Annual
Report
April 2025 to March 2026**

June 2026

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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 certain types of incidents occur, the people are informed about what happened, receive an apology, and the organisation identifies learning to improve services. Openness and honesty are central to maintaining trust and effective communication when unintended or unexpected harm has occurred.

An important part of this duty is the requirement to publish an annual report describing the operation of the organisational Duty of Candour process and any events that have triggered its use.

This is the final Duty of Candour annual report produced by NHS National Services Scotland (NSS). On 1 April 2026, Public Services Delivery (PSD) Scotland was established bringing together the functions of NSS and NHS Education for Scotland (NES). Future Duty of Candour reporting will be taken forward through the new organisational arrangements.

This report describes how NSS has operated the organisational Duty of Candour process during the period between 1 April 2025 and 31 March 2026.

For further information about this report contact psd.contact-us@nhs.scot.

About NHS National Services Scotland

NHS NSS began operating as the Common Services Agency in 1974 because of The National Health Service (Functions of the Common Services Agency) Order 1974. Its mandate was to provide national strategic support services and expert advice to Scotland's health sector with a focus on 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 across the wider public sector in Scotland. Over the next 12 years, NSS continued to deliver a wide

range of national services and managed approximately one-third of the NHS Scotland budget.

On 1 April 2026, PSD Scotland was launched bringing together the existing functions of NSS and NES. This new organisation provides a single point of accountability and delivery for a wide range of support, training and digital services across Scotland's health and public sectors.

Information About Our Policies and Procedures

How NSS reports, records and manages adverse events is outlined in the NSS Adverse Event Management Policy and its associated procedure. The procedure advises staff to contact their line manager when an event occurs that may meet the criteria for organisational Duty of Candour. The Duty of Candour lead in NSS is the Executive Medical Director.

The Duty of Candour section included within the procedure was superseded in November 2025 by a standalone NSS Duty of Candour guidance document. This update followed the publication of revised non-statutory guidance by the Scottish Government in April 2025. The updated guidance provides additional clarity for staff on the distinction between professional and organisational duties of candour, places greater emphasis on staff support and training, enhances decision-making tools, includes real-world examples, and provides a step-by-step guide through the duty. Awareness-raising sessions were delivered across directorates, and the guidance is accessible on the staff intranet.

When a possible organisational Duty of Candour incident is identified, a discussion takes place involving clinicians, Duty of Candour leads, the clinical governance team, information governance (in cases involving data breaches) and partner agencies, including other health boards where appropriate. Given the complexity of national services, such as screening programmes and national IT systems, consideration is also given to Duty of Candour in its broader context, including application within Public Health.

All adverse events undergo review. It is not always immediately clear whether an adverse event meets the legally defined threshold for organisational Duty of Candour, and this may only become evident through the review process or when a

clinical concern is raised later. As soon as a review identifies that the level of harm meets the threshold, the organisational Duty of Candour process is enacted. Reviews focus on learning to understand what happened and identify how care and services can be improved. Following a review, the relevant team develops an improvement plan with actions monitored and learning shared.

Reporting on adverse events, including where Duty of Candour has been applied, is managed through the NSS clinical governance structure. Directorate-level teams and their governance groups meet monthly or quarterly. Corporate oversight is provided through the NSS clinical governance and quality improvement monthly business meeting, with board-level assurance delivered via the NSS Clinical Governance Committee.

Duty of Candour leads are appointed in the Scottish National Blood Transfusion Service (SNBTS) to oversee decision-making and ensure consistent application of the procedure. Given strict regulatory requirements, SNBTS also has additional policies and guidance for reporting blood related incidents to external authorities. In 2021, SNBTS introduced the organisational Duty of Candour Standard Operating Procedure to give staff clear internal guidance on how to fulfil the duty consistently. The procedure was updated in 2025, and awareness-raising sessions held with SNBTS staff.

Training and Support for Staff

NSS is committed to supporting staff involved in adverse events, ensuring that support is offered at a time and in a way that meets individual needs. Staff may experience physical or psychological effects following an event, and it is important that appropriate support is available. Line managers are responsible for checking in with staff and helping to identify appropriate support options. This may include protected time to prepare for a review, referral to occupational health, advice on counselling services and/or contact with their staff side representative.

An internal occupational health and wellbeing portal is available to provide further information, signposting and guidance for both staff and line managers.

Support for the Relevant Person

In all cases where an adverse event occurs, clinicians have a professional Duty of Candour, requiring them to inform the person that something has gone wrong or that an error has occurred, offer an apology, take any immediate action to address safety concerns, and provide support to the person affected.

When an adverse event meets the threshold for organisational Duty of Candour, arrangements are made to ensure that the relevant person and their family or support network are kept informed and involved throughout the process. Regular contact is agreed, and the approach taken reflects compassion and understanding.

Within SNBTS, donors may also be provided with information leaflets if an issue has occurred during their donation.

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

NSS provides few services that are directly public-facing outside of SNBTS patient services and donor services. During 2025-2026, SNBTS had 92,408 active donors with 136,218 donations completed. NSS most often operates as a support organisation or shares responsibility for delivering services that are not frontline for NSS, such as abdominal aortic aneurysm, bowel, breast, and cervical screening programmes. NSS also delivers substantial national digital support services. Given the diverse nature of services, all adverse events are reviewed to determine whether the principles of organisational Duty of Candour apply.

In the last year, there was one event to which the organisational Duty of Candour applied. The event was identified through the adverse event management process, and a significant adverse event review (SAER) was commissioned. The review determined that the patient required an increase in treatment, extended duration of inpatient care, and inter-hospital transfer, thereby meeting the threshold for organisational Duty of Candour (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	1
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	0
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?

The decision to apply Duty of Candour was taken after completion of the SAER rather than at the time of the adverse event. The person involved had been notified of the SAER process and was invited to identify any issues they wished to be considered as part of the review. The person died before completion of the SAER and the Duty of Candour decision. This was unrelated to the event.

When the requirement for Duty of Candour was identified as part of the SAER, this was implemented and all associated timescales were adhered to.

Their person's family was informed that the organisational Duty of Candour process had been initiated and received a written apology and a final copy of the SAER report, including the learning identified to support service improvement.

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

A SAER was commissioned in relation to this event. As part of ongoing improvement work, the SAER process itself has been reviewed and updated guidance aims to clarify roles and responsibilities at each stage of the process and to set out clearer timescales for completion.

An action plan was developed and implemented in response to the learning identified from this adverse event.

This included improvements in communication, handovers and introduction of a pre procedure checklist.

Other information

As required by legislation, Scottish Ministers have been notified that this report has been published on the PSD Scotland website.

The organisational Duty of Candour Lead for NSS, and now PSD Scotland, is the Executive Medical Director, Sharon Hilton-Christie.