NHS
Eileanan Siar
Western Isles

DUTY OF CANDOUR ANNUAL REPORT

1st April 2023 – 31st March 2024

Responsible Officer:
Fiona MacKenzie Nurse/AHP Director and Chief Operating Officer

Approved by Corporate Management Team 18.06.24

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1 INTRODUCTION

The Health (Tobacco, Nicotine etc. and Care) Scotland Act 2016 ("The Act") introduced an organisational Duty of Candour on healthcare and social work services. The Act is supplemented by the Duty of Candour Procedure (Scotland) Regulations 2018, which highlight the procedure to be followed whenever a duty of candour adverse event has been identified.

The requirements of the legislation relating to organisational duty of candour apply to all health and social care services in Scotland and 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 are informed by the organisation of what has been learned and how improvements for the future will be made.

NHS Western Isles is fully committed to the provision of high-quality health care in all aspects of its service provision to patients. As part of this objective, we have a duty to limit the potential impact of a wide variety of clinical and non-clinical risks. We do this by developing and implementing robust and transparent systems to ensure that all adverse events, which may cause potential or actual harm, are identified, investigated and where appropriate action is taken to prevent a recurrence.

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 short report describes how NHS Western Isles has operated the duty of candour during the time between 1 April 2023 and 31 March 2024.

During the period 1st April 2023 – 31st March 2024 there were no adverse events reported in NHS Western Isles that triggered the duty of candour criteria.

2 NHS WESTERN ISLES

NHS Western Isles (otherwise known as Western Isles Health Board) is the organisation responsible for providing healthcare to the population of the Western Isles, which is made up of approximately 26,500 people. We employ 1066 (883.69 WTE staff).

Who we are and what we do…

As a Health Board, our mission statement is to be 'the best at what we do' and our overall purpose is:

> 'to protect, promote and improve the health and wellbeing of the Western Isles population and to ensure the reliability and delivery of sustainable and safe healthcare and services'.

NHS Western Isles works alongside mainland Health Boards and other local organisations, including the local authority and third sector (voluntary) organisations, to provide a wide range of healthcare services to the local population. Where possible, services are provided locally,

in the Western Isles, but for specific procedures and more specialist services, we work with mainland partners to provide services in other areas.

There are three hospitals in NHS Western Isles. The largest is the Western Isles Hospital located in Stornoway which has 48 staffed adult inpatient beds and 16 contingencies, 4 High Dependency Unit beds and 3 Paediatric beds. In addition, there are 5 Acute Psychiatric beds, 6 Maternity beds and 16 covid surge capacity beds.

Ospadal Uibhist agus Bharraigh (Uist and Barra Hospital) is located in Benbecula. The hospital has 16- 20 beds which includes 1 palliative care room, 1 resus room and 1 will be a place of safety room. Many of the Consultants from the Western Isles Hospital, and some from mainland Health Boards, visit the Uist and Barra Hospital to provide outpatient services.

St Brendan's Hospital, with 3 inpatient beds, is located in Castlebay on the Isle of Barra and is in a shared building with a local authority care home facility.

3 POLICIES & PROCEDURES

All adverse events and near misses are reported through NHS Western Isles Risk Management system (Datix), as set out within our Framework for Reporting, Managing and Learning from Adverse Events.

This system has now been developed to include a section on the Duty of Candour which is triggered if staff record that the adverse event reported has the potential to meet the duty of candour procedure. Consequently, through the adverse event reporting and review process together with the duty of candour procedure adverse events that could trigger the duty of candour process will be identified.

Furthermore, all our category 1, 2 and 3 adverse events are reviewed in accordance with our Framework to understand what happened and to establish if there any actions to be included in the improvement plan that can be taken to prevent/ minimise a recurrence and/ or improve patient care.

The following time frames must be followed for reviewing adverse events:

> **Category 1** – Commission a Significant Adverse Event Review within 10 working days of the adverse event being reported on to Datix. Commence and close review (report submitted for approval within 90 working days of adverse event being reported on to Datix. Final approval should take place as soon as possible and no later than 30 working days from report submission.
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> **Category 2** – Commence review within 10 working days of the adverse event reported on to Datix. Close review (report submitted for approval within 30 working days of the adverse event reported on Datix).

Category 3 – Adverse event approved and closed within 10 working days of adverse event reported on to Datix.

4 TRAINING

Members of staff responsible for inputting adverse events onto Datix and for reviewing these records receive training on the use of the Datix reporting system. Clinicians are also encouraged to complete the Duty of Candour TURAS e learning training module.

5 DUTY OF CANDOUR – GOVERNANCE & MONITORING

The Risk Manager currently reviews all adverse events reported on to Datix and monitors activity relevant to the Duty of Candour process. All potential adverse events identified for the Duty of Candour process will be escalated by the Risk Manager via the line management process to the Head of Clinical Governance and Practice Development.

The Datix records identified are then discussed at the Risk Management Review meetings with the Nurse/ AHP Director & Chief Operating Officer and the Medical Director. Following discussion agreement is then reached on whether the Duty of Candour process requires to be commenced.

Furthermore, the following information sources are also utilised in order to identify potential duty of candour adverse events.

Category 1, 2 and 3 adverse event reviews

- Significant Adverse Event reviews
- Complaints
- Patient Safety adverse events reported to the Health and Safety executive such as RIDDOR
- Child protection/ contact issues
- Patient adverse events reported to Health Protection Scotland

An adverse event report is produced and discussed at the Learning Review Group and Clinical Governance Committee.

6 DUTY OF CANDOUR
Adverse Events.

The outcomes are:

a) the death of the person,

b) a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (including removal of the wrong limb or organ or brain damage) (“severe harm”),

c) harm which is not severe harm but which results in—

i. an increase in the person’s treatment,
ii. changes to the structure of the person's body,
iii. the shortening of the life expectancy of the person,
iv. 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,
v. 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.

From the 1st April 2023 – 31st March 2024 NHS Western Isles had no adverse events reported that met the above duty of candour criteria.

7 FURTHER INFORMATION

Following on from last year’s report we continue to make amendments to the information we record following adverse events and complaints. This enables us to record the evidence from the reporting stage to completion of the key steps in the duty of candour procedure.