NHS
Eileanan Siar
Western Isles

DUTY OF CANDOUR ANNUAL REPORT

1st April 2025 – 31ST March 2026

Responsible Officer	Dr Sara Else	Medical Director

DUTY OF CANDOUR REPORT

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(s) learns how to improve for the future.

An important part of this duty is that we provide an annual report about the organisational duty of candour in our services. This report describes how NHS Western Isles has operated the organisational duty of candour during the time between 01 April 2025 and 31 March 2026. We hope you find this report informative.

ABOUT 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.

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 17 contingency beds.

Ospadal Uibhist agus Bharraigh (Uist and Barra Hospital) is located in Benbecula. The hospital has 16 inpatient beds and 4 contingency beds.

St Brendan's Hospital, with 3 inpatient beds and 2 contingency beds, is located in Castlebay on the Isle of Barra and is in a shared building with a local authority care home facility.

Every adverse event is reported through the InPhase Risk Management system as set out in the Framework for Adverse Event Reporting, Management and Learning and associated procedures. Reporting may be retrospective if an adverse event is identified through a claim, complaint, or other means.

The adverse event management process enables the identification of adverse events that trigger the Duty of Candour procedure. The framework contains details on communicating with patients and families about adverse events, including Duty of Candour. Each adverse event is reviewed to understand what happened and how we might improve the care provided in the future. The level of review depends on the severity of the event as well as the potential for learning. Recommendations are made as part of the adverse event review, and relevant management teams develop improvement plans to meet these recommendations.

TRAINING

Members of staff responsible for inputting adverse events onto InPhase and for reviewing these records receive training on the use of the InPhase risk management system. Staff are also encouraged to complete the Duty of Candour TURAS e-learning training module.

HOW MANY ADVERSE EVENTS HAVE OCCURED WHERE THE DUTY OF CANDOUR HAS APPLIED

In the last year, there have been 3 adverse events to which the organisational duty of candour applied. These are events that have happened which are unintended or unexpected, and do not relate directly to the natural course of someone's illness or underlying condition.

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

In each of these events a member of the medical team has spoken with the relevant person.

Due to the small number of events, the information presented within this report is intentionally high-level in order to preserve confidentiality and maintain anonymity.

NHS Western Isles identified these incidents through our adverse event management process although these can be highlighted through other routes such as a complaint.

WHAT HAS CHANGED AS A RESULT? /WHAT HAVE WE LEARNT?

For each Duty of Candour event, where appropriate an associated improvement plan has been, or is in the process of being, developed to ensure that learning is identified, implemented, and effectively shared. These improvement plans are presented alongside the adverse event report at the Learning Review Group and the Clinical Governance Committee, where they are subject to scrutiny and provide assurance that appropriate actions have been taken to support continuous improvement.

OTHER INFORMATION

As required by the legislation, we have notified Healthcare Improvement Scotland that this report has been published.

Within NHS Western Isles the Medical Director is responsible for organisational Duty of Candour.