1. **Introduction**

All health and social care services in Scotland have a 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 are informed by the organisation what has been learned and how improvements for the future will be made.

An important part of this duty is that we publish an annual report which describes how NHS Highland has operated the duty of candour procedures during the time between 1 April 2022 and 31 March 2023.

1. **About NHS Highland**

Port Appin Medical Practice serves a population of approximately 900 people across Appin, Port Appin, Isle of Lismore, Duror & Kentallen.

Our aim is to provide high quality care for every person who uses our services.

1. **How many incidents happened to which the duty of candour applies?**

Between 1 April 2022 and 31 March 2023, there were 0 incidents where the duty of candour applied. These are unintended or unexpected incidents that result in death or harm as defined in the Act, and do not relate directly to the natural course of someone’s illness or underlying condition.

Over the time period for this report we carried out and concluded 0 significant event analyses. These events 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 cause significant harm. Significant event analyses are also undertaken where there is no harm to patients or service users, but there has been a significant impact to service or care delivery.

We identify through the significant event analysis process if there were factors that may have caused or contributed to the event, which helps to identify duty of candour incidents.

Table 1.

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| --- | --- |
| **Type of unexpected or unintended incident (not related to the natural course of someone’s illness or underlying condition)** | **Number of times this happened (between 1 April 2022 and 31 March 2023)** |
| A person died | 0 |
| A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions | 0 |
| A person’s treatment increased | 0 |
| The structure of a person’s body changed | 0 |
| A person’s life expectancy shortened | 0 |
| A person’s sensory, motor or intellectual functions was impaired for 28 days or more | 0 |
| A person experienced pain or psychological harm for 28 days or more | 0 |
| A person needed health treatment in order to prevent them dying | 0 |
| A person needing health treatment in order to prevent other injuries as listed above | 0 |
| **TOTAL** | 0 |

1. **Information about our policies and procedures**

Each adverse event is reviewed to understand what happened and how we might improve the care we provide 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 Iona Ferguson, Practice Manager must take action to implement these recommendations. These are followed up until conclusion.