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 2020 and 31 March 2021.

2. About NHS Highland

Port Appin Medical Practice serves a population of approximately 920 people across both Appin and the Isle of Lismore.

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

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

Between 1 April 2020 and 31 March 2021, 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.

Port Appin Medical Practice identified these incidents through our adverse event management procedures. 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.

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 2020 and 31 March 2021)**
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

4. To what extent did Port Appin Medical Practice follow the duty of candour procedure?

When we realised the events listed above had happened, we followed the correct procedure in 0 occasions 100% of the time). This means we informed the people affected; apologised to them; offered to meet with them; reviewed what happened and what could have been better and fed back the findings to the people affected if this was their wish.

[Commentary for reasons why the procedure was not followed if not followed]

5. Information about our policies and procedures

Every SEA event is reported through our local reporting system as set out in our [SEA management procedures]. Through our [SEA management procedures] we can identify incidents that trigger the duty of candour procedure.

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 we take action to implement these recommendations. These are followed up until conclusion.

Staff receive training on adverse event management and incident reporting as part of their induction.
We know that adverse events can be distressing for staff as well as people who receive care. We have support available for all staff through our GPs support.

6. What has changed as a result?

We have made a number of changes following review of adverse events which have been identified as meeting the criteria of duty of candour. Please see the following cases as examples:

Examples

7. Other information

As required, we have placed this report on our website.

If you would like more information about this report, please contact us using these details:

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