The Glencairn Medical Practice
Duty of Candour Report 2020

All health and social care services in Scotland have a duty of candour. In addition to a professional duty of candour, this is a legal requirement which means that when unintended or unexpected adverse events happen that result in death or harm as defined in the Act, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future. 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 The Glencairn Medical Practice has operated the duty of candour during the time between 1 April 2019 and 31 March 2020. We hope you find this report useful.

1. About Glencairn Medical Practice

The Glencairn Practice serves a population of approximately 9800 people in Motherwell and the surrounding area. Our aim is to provide high quality care for every person who uses our services, and where possible help people to receive care at home.

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

Between 1 April 2018 and 31 March 2019, there were no incidents where the duty of candour applied. Such incidents are unintended or unexpected events 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.

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 2019 and 31 March 2020)
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**

Glencairn Medical Practice
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3. To what extent did The Glencairn Medical Practice follow the duty of candour procedure?

We actively sought out cases to which a Duty of Candour might apply but did not find any. To this extent we were fully compliant with the duty of candour procedure.

4. Information about our policies and procedures

Where something has happened that has the potential to trigger duty of candour, our staff report this to the Practice Lead for Duty of Candour, who is also responsible for Complaints Handling within the Practice and this is currently Dr A Porte. Dr Porte also has responsibility for ensuring that the duty of candour procedure is followed. The manager records the incident and reports as necessary to the Care Inspectorate. When an incident has happened, the manager sets up a learning review. This allows everyone involved to review what happened and identify changes for the future.

All new staff learn about the duty of candour at their induction. We know that serious mistakes can be distressing for staff as well as patients and their families.

The Glencairn Practice identifies such incidents through our adverse event management process. We regularly carry out significant adverse event reviews. 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.

We would hope to identify through the significant adverse event review process any factors that may have caused or contributed to the event, which helps to identify duty of candour incidents.

5. What has changed as a result?

We have not identified any Duty of Candour events this year and so there are no resulting changes to report.

6. Other information

This is the second year of the duty of candour being in operation and it has continued to be a year of learning and refining our existing adverse event management processes to include the duty of candour outcomes.

Last year we submitted a copy of our Duty of Candour report to DutyofCandour@gov.scot however received an email from Linda.Kemp@careinspectorate.gov.scot dated 07/02/20 advising that "Your are not required to submit this report to the Care Inspectorate……the legislation requires services to prepare a report and to have it available to relevant agencies on request". We have therefore not submitted this report to Scottish Ministers but have placed it on our website.
If you would like more information about this report, please contact us using these details:

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