GLEBE MEDICAL PRACTICE

Abbeygreen, Lesmahagow, Lanark ML11 0DB

Duty of Candour Report 2024-25

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 Glebe Medical Practice has operated the duty of candour during the time between 1 April 2024 and 31 March 2025. We hope you find this report useful.

1. About Glebe Medical Practice

Glebe Medical Practice serves a population of approximately 6,400 people in Lesmahagow, Brocketsbrae, Hawksland, Dillarburn, Kirkmuirhill, Blackwood and Auchenheath. 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 2024 and 31 March 2025, there was one incident which occurred din November 2024 but was raised/realised in May 2024 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 2024 and 31 March 2025)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	1
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	**1**

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

We realised when a complaint was received that the duty of candour should be engaged. We apologised for the error and met with the patient and her representative to explain why it happened and how we learned from it. We also advised on the steps taken to ensure this does not happen in the future. We wrote to the patient with the minutes of the meeting and as per their own instruction, awaited further input. However the patient did not respond therefore the matter was closed. 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 Senior GP who has responsibility for ensuring that the duty of candour procedure is followed. The Practice Manager records the incident. 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.

Glebe Medical 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 held a Significant Event Analysis meeting. As a result of the review, the practice nurses took a refresher course in ear care. The practice also re-iterated that if the nurse are unsure of anything, to seek further advise/a second option form the GP's.

6. Other information

As required, we have advised the Scottish Ministers that this report has been published and placed it on our website.

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

Glebe Medical Practice, Abbeygreen, Lesmahagow, Lanark ML11 0DB

Tel: 01555 892328; Email: glebe.medicalcentre@lanarkshire.scot.nhs.uk

Website: www.glebemedicalpractice.co.uk