**Duty of Candour Report**

**Cadzow Health Centre, 187 Low Waters Road, Hamilton. ML3 7QQ**

**Duty of Candour Annual Report**

**1st April 2020 – 31st March 2021**

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| Duty of Candour Lead: | **Ann Wilson, PM** | **Interval Review** | **Yearly or when SEA occurs** |
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1. **Background**

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 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 report describes how Cadzow Health Centre has operated the duty of candour during the time between 1 April 2018 and 31 March 2019. We hope you find this report useful. It is worthwhile noting that Cadzow Health Centre may often only play a small part in the patient’s full journey of care. While impact or outcomes are not always known, where opportunities for learning and improvements are identified through our significant event process or following feedback from other health and social care services, these will be addressed.

1. **About the Practice**

The practice is an independent contractor to Lanarkshire’s NHS board. We provide General Medical Services to our practice population of around 5,100, based mainly in and around Hamilton. The practice meet regularly to review significant events following any adverse incidents and where appropriate discuss the need to apply the Duty of Candour. This is of particular importance to not only comply with the Act but also to ensure as a training practice that our new doctors are aware of their responsibilities.

1. **How many incidents happened to which the Duty of Candour applies?**

Between 1 April 2020 and 31 March 2021, there were no incidents where the duty of candour applied i.e. there were no incidents where all unintended or unexpected incidents that resulted in death or harm as defined in the Act and did not relate directly to the natural course of illness or an underlying condition. Over the time period for this report we carried out 5 Significant Event Reviews.   
  
Through the Significant Events Review process, we determine if there are factors that may have caused or contributed to the event, which helps to identify duty of candour incidents. Type of unexpected or unintended incident (not related to the natural course of someone’s illness or underlying condition).

1. **Number of times this happened (between 1 April 2020 and 31 March 2021)** Total = 0
2. **To what extent did Cadzow Health Centre follow the duty of candour procedure?** Not applicable

If you would like further information regarding this report, please contact:

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