

Duty of Candour Policy

Links Medical Practice

Date issued: 02/06/26

Review date: 02/06/27

Responsible Lead: Practice Manager

1. Purpose

This policy sets out how the practice will meet its legal duty of candour.

We are committed to being open, honest and supportive when something goes wrong. Our aim is to ensure patients are treated fairly, kept informed, and supported, and that we learn from incidents to improve care.

2. What is Duty of Candour

The duty of candour is a legal requirement in Scotland. It applies when a patient is harmed, or could have been harmed, as a result of care or treatment provided by the practice.

When this happens, we must:

- Inform the patient or their representative
 - Explain what happened
 - Apologise
 - Offer a meeting
 - Review the incident and learn from it
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3. Reporting incidents

All staff must report any incident where harm has occurred, or may have occurred, as soon as possible through normal line management routes.

This ensures the situation can be reviewed quickly and appropriate action taken.

4. When the procedure is triggered

The duty of candour process starts when the practice becomes aware of an incident that has caused, or could have caused, harm, and this is confirmed by an appropriate health professional.

5. Key steps

Once the duty of candour applies, the practice will:

Initial contact

The patient (or their representative) will be contacted within 10 working days and given a clear explanation of what is known so far.

Communication

The patient's preferred method of communication will be agreed (for example phone, letter, email or face to face).

Meeting

Where appropriate, a meeting will be offered to:

- Explain what happened
- Answer questions
- Listen to the patient's views
- Explain what will happen next

Apology

A sincere apology will be given. This is an acknowledgement of what happened and does not imply liability.

Review

The practice will carry out a review of the incident, usually through significant event analysis, to understand:

- What happened
- Why it happened
- What can be improved

A written summary and any learning will be shared with the patient where appropriate.

6. Support

We will ensure that:

- Patients are offered appropriate support throughout the process
 - Staff involved are also supported
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7. Record keeping

A full record of the incident and all actions taken will be kept in line with NHS Scotland record keeping requirements.

8. Culture

We encourage a culture where staff feel able to speak up about concerns. The focus is on learning and improving, not blame.
