Duty of Candour Report

January 2023-December 2023

All health care services in Scotland have a duty of candour. This is a legal requirement which means that when things go wrong and mistakes happen, 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 the duty of candour in our services. This short report describes how our clinic has operated the duty of candour during the time between 1st Jan 2023 and 31 December 2023. We hope you find this report useful.

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

In the last year, there have been no incidents to which the duty of candour procedures applied.

2. Information about our policies and procedures

Where something has happened that triggers the duty of candour, the Clinical Director has a responsibility for ensuring that duty of candour procedure is followed. The Clinical Director records the incident and reports as necessary to Health Care Improvement Scotland. When an incident has happened, the Clinical Director sets up a learning review. External Subject Matter Experts may be consulted during the process. This allows everyone involved to review what happened and identify changes for future care. Any new staff to the clinic will learn about the duty of candour at their induction. We know that serious mistakes can be distressing for the clinical staff as well as people who use the service. When anyone has been affected by a duty of candour incident, we can arrange to have in place welfare support as necessary.

If you would like more information about our clinic and the services we provide, please contact us using these details:

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