The 'duty of candour'

The duty of candour

The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018 (the Regulations) set out a new Duty of Candour.

The Act and the Regulations require organisations providing health services, care services and social work services in Scotland to follow a formalised procedure when there has been an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm).

The purpose of this new duty is to ensure that providers are open, honest, supportive and providing a person-centred approach.

Our legal obligations

1. Duty of Candour Procedure

As a provider of an independent healthcare service, we are required to develop and implement a duty of candour policy that describes how we/our staff will act in the event of an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm).

The key stages of the policy must include:

- → Notify the person affected (or family/relative where appropriate);
- → Provide an apology;
- → Carry out a review into the circumstances that led to the incident;
- → Offer a meeting with the person affected and/or their family, where appropriate;
- → Provide the person affected with an account of the incident;
- → Provide information about further steps taken;
- → Provide support to staff notifying the person affected by the incident;
- → Prepare and publish an annual duty of candour report (see below).

Further guidance on when the duty must be implemented can be found in the Scottish Government Duty of Candour Guidance and the dedicated webpage.

Preparing the duty of candour procedure:

We will consider the following points when preparing the duty of candour procedure and annual report:

- How we will identify the incidents that trigger the Duty of Candour procedure, as outlined in section 21 of the Act?
- We are satisfied our staff understand their responsibilities and we have systems in place to respond effectively?
- Who do we need to engage with to satisfy ourselves we can meet the responsibilities of the Duty and deliver the requirements outlined in the Act?
- What systems we have in place to support staff to provide an apology in a person-centred way and how we support staff to enable them to do this?
- Do our current systems and processes provide the information required to report on the Duty of Candour?
- How we will align our duty of candour annual report with other reports we are required to provide, such as feedback and complaints, significant events reviews, case reviews etc.?
- What training and education we have at present that will support the implementation of the Duty? This could be training that considers issues such as how to give an apology, being open, meetings with families, dealing with difficult situations.
- What we have available for people involved in invoking the procedure (staff) and those affected (staff and service users)?
- How we currently share lessons learned and best practice around incidents of harm? Could this be improved in any way?

**Please refer to the Duty of Candour Guidance for more detailed guidance.*

2. Duty of candour annual report

We must prepare and publish a duty of candour report at the end of each financial year, providing information about when and where we have applied the duty of candour. This annual report will be published on our website.

NB: *Even if you do not implement the duty of candour procedure in a given year, you are still required to produce a short report that contains information about staff training on the duty of candour obligations.*

Duty of Candour Annual Report

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Services must tell the patient, apologise, offer appropriate remedy or support and fully explain the effects to the patient.

As part of our responsibilities, we must produce an annual report to provide a summary of the number of times we have triggered duty of Candour within our service.

Name & address of service:	MMV Nails, Beauty and Tanning Ltd, 111 Drip Rd, Stirling FK8 1RW	
Date of report:	11 March 2025 (for period 1 January 2024 – 31 December 2024)	
How have you made sure that you (and your staff) understand your responsibilities relating to the duty of candour and have systems in place to respond effectively? How have you done this?	Staff fully understand the responsibilities relating to the Duty of Candour. As an organisation, we have systems in place which include as outlined above, to respond effectively.	
Do you have a Duty of Candour Policy or written duty of candour procedure?	YES	

How many times have you/your service implemented the duty of candour procedure this financial year?	
Type of unexpected or unintended incidents (not relating to the natural course of someone's illness or underlying conditions)	Number of times this has happened (Jan 24 – Dec 24)
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

Document based on IHC Duty of Candour Template for Providers, Version 1.0, dated 19 February 2019 prepared by IHC team

Did the responsible person for triggering duty of candour appropriately follow the procedure? If not, did this result in any under or over reporting of duty of candour?	There were no Duty of Candour events during this period. However, all healthcare professionals understand they have a duty of candour and a professional responsibility to be honest and communicate effectively when things go wrong and to follow the terms of the Duty of Candour Policy
What lessons did you learn?	N/A. There were no incidents. However, following any incident, whether Duty of Candour is implemented or not, an immediate investigation is carried out. If necessary, risk assessments would be updated or created in response to any incident.
What learning & improvements have been put in place as a result?	Professional accountability and accurate documentation must always be in place.
Did this result is a change / update to your duty of candour policy / procedure?	N/A. However, we continue to follow the template provided by Healthcare Improvement Scotland and would notify HIS using their Notifications Guidance as and when appropriate.
How did you share lessons learned and who with?	N/A. All learning would be shared by the team and if there was an incident which triggered duty of candour. If appropriate, any lessons would also be shared with the wider aesthetics community.
Could any further improvements be made?	As there were no incidents, no improvements have been identified but we continue to monitor best practice to mitigate the risk of any incident.
What systems do you have in place to support staff to provide an apology in a person-centred way and how do you support staff to enable them to do this?	Staff have undertaken the appropriate Duty of Candour training and understand the process and manner involved in providing an apology following any incident.
What support do you have available for people involved in invoking the procedure and those who might be affected?	All staff would be fully supported in the application of the policy in the event of any incident. Our Emergency Response protocol would be implemented for any person who has been harmed and they would be provided the opportunity to discuss the incident with a senior member of the team. Information detailing the processes and steps taken following an incident is set out in the Duty of Candour Policy.
Please note anything else that you feel may be applicable to report.	Nothing at this time but we will continue to review, monitor and develop our policy. As regulated, a copy of this Annual Report is available in the salon and online. Any practitioner operating within the salon under practising privileges must be able to evidence their understanding of the principles of Duty of Candour and specifically those set by the NMC: https://www.nmc.org.uk/standards/guidance/the-professional-duty-of-candour/ Caring with confidence – the Code in action https://www.nmc.org.uk/standards/code/code-inaction/