



## **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 trigger Duty of Candour within our service.

Name & address of service:	St Ellen's Private Hospital, 410 Sauchiehall Street, Glasgow, G2 3JD	
Date of report:	02 April 2025	
How have you made sure that you (and	Cosmedicare UK Limited first published our Duty of Candour Policy in	
your staff) understand your	January 2021. Regular communications relating to online training have	
responsibilities relating to the duty of	been made across the workforce, through emails, company chat groups	
candour and have systems in place to	and team meetings. The Policy and Standard Operating Procedure have	
respond effectively?	been circulated to all employees and remain available at all times via our	
	digital network, within our online Incident Management System, for which	
How have you done this?	all our employees have their own user accounts, and in hard-copy format in	
	the Employee's Policy Folder held onsite in the employee break areas.	
	All new starts complete Duty of Candour training during their induction	
	period and it is mandatory for all employees to undertake annual refresher	
	Duty of Candour training through our online Learning Management System.	
Do you have a Duty of Candour Policy or	Yes	
written duty of candour procedure?		

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	Number of times this has happened			
course of someone's illness or underlying conditions)	(April 2024 - March 2025)			
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			

Did the responsible person for triggering	Not applicable.
duty of candour appropriately follow the	
procedure?	
If not, did this result is any under or over	
reporting of duty of candour?	
What lessons did you learn?	Not applicable.
What learning & improvements have	Not applicable.
been put in place as a result?	

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Did this result is a change / update to your duty of candour policy / procedure?	Not applicable.
How did you share lessons learned and who with?	Not applicable.
Could any further improvements be made?	Not applicable.
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?	We have a clear Duty of Candour Policy and Standard Operating Procedure in place with is aligned with Healthcare Improvement Scotland's guidance, including what constitutes a duty of candour incident, what steps employees should take, who to tell and timelines for doing so. Duty of Candour mandatory eLearning training module is in place for all staff, which includes duty of candour legal and ethical responsibilities, communicating bad news and giving apologies empathetically and role-played simulations for real-world preparation. This training module must be refreshed annually or post-incident review. Periodic audits of duty of candour process to ensure policy is followed and apologies are documented appropriately
What support do you have available for people involved in invoking the procedure and those who might be affected?	A member of the senior management team is always present or available for all staff members and they will support and mentor team members required to deal with any incidents. 1-1s with staff members are carried out by clinical leads post-incident to assess how well they felt supported.
Please note anything else that you feel may be applicable to report.	Senior team members are expected to actively role model transparency and compassionate communication at all times and to ensure they visibly support staff who are open and honest, even when outcomes are difficult.  The organisation's Incident Management System is widely utilised by all St Ellen's employees and the system prompts users of the system to consider our duty of candour when recording any incident, including applicability of duty of candour in each instance, whether and how it has been invoked, who was involved, etc. All incidents logged are flagged to the senior management team, line managers and team leads who also have oversight of how each incident is being managed through the system, helping us to ensure that the process is properly invoked when applicable and identify where and how the wider workforce needs support and oversight during the process.

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