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, 2 Garbett Road, Livingston, EH54 7DL
Date of report:	02 April 2025
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?	Cosmedicare UK Limited first published our Duty of Candour Policy in January 2021. Regular communications relating to online training have been made across the workforce, through emails, company chat groups and team meetings. The Policy and Standard Operating Procedure have been circulated to all employees and remain available at all times via our digital network, within our online Incident Management System, for which 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 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 (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	1
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	1
A person needing health treatment in order to prevent other injuries as listed above	9
Total	11

Did the responsible person for triggering duty of candour appropriately follow the procedure? If not, did this result is any under or over reporting of duty of candour?	Yes
What lessons did you learn?	That it is vital to continuously promote and support a just culture where staff feel psychologically safe to report all incidents and offer an apology to our service users without fear of disproportionate blame. The importance

	of holding structured debriefs to allow all staff, regardless of their role, to freely discuss what happened, what went well and what could have been improved, building in transparency and optimising learning opportunities for the wider team too. The requirement to have an on-call clinical leadership presence, ideally with experience in medical incident management, to provide immediate emotional and practical support to clinical staff members.
What learning & improvements have been put in place as a result?	The routine introduction of holding post-incident reflective sessions that include communication practices, emotional impact and learning from events which further embeds "learning not blaming" as our default approach in incident reviews. Introduction of Duty of Candour training within the first two weeks induction for all new starts. Monitoring of all surgical debriefs for clarity and completion and enabling wider and routine sharing of any significant matters as part of the clinical governance team meetings.
Did this result is a change / update to your duty of candour policy / procedure?	Yes – the detail within the policy relating to how we manage feedback and monitoring of the Duty of Candour process was expanded to include reference to debriefs, reflective practices, promotion of a just culture, greater leadership visibility and role modelling, and internal audit practices.
How did you share lessons learned and who with?	Lessons learned are shared via daily huddles and through surgical debriefs, incident recording within the organisation's Incident Management System and review of these incidents during clinical and governance meetings.
Could any further improvements be made?	We recognise our obligation to continue to seek improvements and to build a stronger culture of learning and safety and recommendations have been forwarded to adopt additional strategies to ensure lessons learned are more effectively shared and embedded across all teams through: 1 Regular Lessons Learned bulletins/newsletter (monthly or bimonthly) with key incidents, their outcomes and learning points being summarised, reinforcing continuous learning in a digestible and accessible format. 2 Integrating learning into mandatory training whereby recent, real-life case studies are incorporated into staff inductions, embedding a culture of openness and learning from day one. 3 Encouragement of "Storytelling" at Team Meetings where clinical staff are asked to share brief (anonymised) patient stories during meetings to humanise the impact and strengthen emotional engagement of lessons learned, especially for those within the team who are new to/relatively fresh in their healthcare careers. 4 Better use of our "You Said We Did" posters around the premises to highlight actions taken from incident learning. 5 To create a guide including how to make an effective and compassionate apology with examples of appropriate language. 6 To create an Apology and Communication toolkit which provides resources such as a written apology template, FAQs for difficult conversations, flowchart showing step by step process post-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?	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.