Duty of Candour Annual Report: 2024 - 2025

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:	The Prince & Princess of Wales Hospice (PPWH) 20 Dumbreck Road, Bellahouston Park, Glasgow, G41 5BW	
Date of report:	April 2024-March 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?	The PPWH ensure understanding of Duty of Candour responsibilities through regular training. As part of annual mandatory and statutory training the clinical staff must complete the LearnPro NES Duty of Candour module. In addition, band 7 team leads have received tailored training on incident reporting including responsibilities for managerial review and identification of which incidents would trigger organisational Duty of Candour. Our systems include protocols for alerting key individuals immediately following a Duty of Candour incident being reported. In addition, all incidents are reviewed and closed by the members of the senior clinical team to ensure any learning and identified improvements have been documented accordingly and are actioned. The hospice Duty of Candour policy outlines the support available to staff and the relevant person.	
Do you have a Duty of Candour Policy or written duty of candour procedure?	YES	NO

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 24 - March 25)
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased (pt 1)	1
The structure of a person's body changed	0
A person's life expectancy shortened	
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 (pt 2)	1
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 duty of candour appropriately follow the procedure? If not, did this result is any under or over reporting of duty of candour?	(pt 1) -Yes (pt 2) - a related complaint was received, and all matters are being managed in line with the hospice complaints policy, a procedure which generates a robust investigation process and associated quality improvement plan where appropriate.
What lessons did you learn?	(pt 1) - we gained the benefits of using the Procurator Fiscal's investigation template to support the review of a serious falls incident. It reassured the clinical team, as well as the organisation, that the appropriate assessments and control measures had been in place, including appropriate communication and support with the relevant people. (pt 2) - investigation in progress.
What learning & improvements have been put in place as a result?	The Procurator Fiscal's investigation template is a useful tool that can be used to undertake a deep dive audit of falls management or the review of any serious falls incidents.
Did this result is a change / update to your duty of candour policy / procedure?	No
How did you share lessons learned and who with?	(pt 1) - Not applicable (pt 2) - Awaiting results of investigation
Could any further improvements be made?	The template supplied by the Procurator Fiscal would be useful to use in the future for a deep dive when conducting a falls audit.
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?	The PPWH support staff in providing person-centred apologies through ongoing training such as our Engage with Compassion workshops. Additionally, feedback and support mechanisms are in place which provide regular opportunities for staff to consider improvements to practice. The education department facilitate regular reflective and mortality review meetings with the clinical teams to foster a safe learning environment. The incident reporting form includes a section for the clinical staff to record any conversations held with the patient and or family in keeping with professional Duty of Candour in addition to their documentation within the electronic patient record.
What support do you have available for people involved in invoking the procedure and those who might be affected?	The PPWH provide support to staff when there is any significant clinical incident including those that trigger Duty of Candour. Improvements are often generated by the team members involved as they feel empowered to change practice.
Please note anything else that you feel may be applicable to report.	Nil