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:	Prince & Princess of Wales Hospice (PPWH) 20 Dumbreck Road, Bellahouston Park, Glasgow, G41 5BW	
Date of report:	April 2023-March 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?	The PPWH ensure understanding of duty of candour responsibilities, both professional and organisational, through regular training. Our systems include protocols to alert 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.	
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 2023 – March 2024)
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 duty of candour appropriately follow the procedure? If not, did this result is any under or over reporting of duty of candour?	Not applicable
What lessons did you learn?	Not applicable
What learning & improvements have been put in place as a result?	Not applicable
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?	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 meetings with the clinical teams to foster a safe learning environment.
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 a Duty Candour . Improvements often being 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