



## Duty of Candour Annual Report: 2025 - 2026

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 2025 - March 2026	
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?	<p>The PPWH ensure understanding of Duty of Candour responsibilities through regular training. As part of annual mandatory and statutory training, 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.</p> <p>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 members of the senior clinical team to ensure any learning and identified improvements have been documented accordingly and are actioned.</p> <p>The hospice Duty of Candour policy outlines the support available to staff and the relevant person.</p>	
Do you have a Duty of Candour Policy or written duty of candour procedure?	<b>YES</b>	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 25 - March 26)	
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	
<b>Total</b>	<b>0</b>	



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?	
What lessons did you learn?	
What learning & improvements have been put in place as a result?	
Did this result in a change / update to your duty of candour policy / procedure?	
How did you share lessons learned and who with?	
Could any further improvements be made?	
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?	
What support do you have available for people involved in invoking the procedure and those who might be affected?	
Please note anything else that you feel may be applicable to report.	