Duty of Candour Annual Report Template

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 St Andrews Practice	
Date of report:	1.4.26	
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?	All staff and clinicians are familiar with Duty of Candour policy and what events trigger duty of candour. We have clear processes of notification and procedures to follow in the event Duty of Candour is triggered. We have clear guidance on our legal obligations.	
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 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	1 - delayed diagnosis
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	1

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?	The service recognised a need for increased quality oversight of procedural adherence for all clinicians regardless of role, seniority or experience.
What learning & improvements have been put in place as a result?	Enhanced diagnostic protocols and report templates to ensure greater clarity and consistency. Increased frequency of supervision and team meetings. Increased frequency of audits and implementation of a standardised process to be used for diagnostic reports and case files. Mandatory quality review process for all new clinicians involved in diagnostic assessments. Further team development and training to build on existing clinical skills in relation to multi-disciplinary diagnostic assessments.
Did this result is a change / update to your duty of candour policy / procedure?	No
How did you share lessons learned and who with?	Yes: • Discussed at management team meetings • Discussed individually and as a team with the clinicians involved in children and young people's service. • A letter has been sent to identified families where assessments were not fully adherent to the organisation's established policies, professional standards of proficiency, and national diagnostic guidelines.
Could any further improvements be made?	Quality reviews and audit outcomes will help to identify any further improvements. Any ongoing training needs will be identified and addressed.
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?	Remedial work has been and continues to be provided by the most appropriate clinicians in the team, free of charge to affected individuals. Verbal and written apologies have been made to those affected. The appropriate member of the management team has discussed individual clients and families with the clinicians involved in initial assessment. Support has been provided and where appropriate the clinician has been directly involved in remedial work.
What support do you have available for people involved in invoking the procedure and those who might be affected?	Regular management meetings, supervision, debrief, checking-in with each other on a regular basis, and access to any additional training and development required.
Please note anything else that you feel may be applicable to report.	The service worked hard to enable positive outcomes for all involved, and has received positive feedback regarding their handling of the situation that arose.