Duty of Candour Annual Report

April 2025 - March 2026

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Introduction

All health and social care services in Scotland have an organisational duty of candour. This is a legal requirement which means that when certain types of incidents happen, the people affected understand what has happened, receive an apology, and the Hospice learns how to improve in the future.

An important part of this duty is that we provide an annual report about the organisational duty of candour in our services. This report describes how our organisation, St Columba's Hospice Care, has operated the organisational duty of candour during the time between 01 April 2025 and 31 March 2026.

If you have any questions or would like more information about St Columba's Hospice, please feel free to contact us at: info@stcolumbashospice.org.uk

How many incidents happened to which the organisational duty of candour applies?

In the last year, there have been no incidents to which the organisational duty of candour applied.

Information About Our Policies and Procedures

St Columba's Hospice Care ensure understanding of duty of candour responsibilities through our policies, systems and training. Duty of Candour requirements are embedded in our operational policies, including the incident reporting and management policy. Our electronic risk management and incident reporting system ensures all incidents are assessed in line with duty of candour requirements. All clinical incidents are automatically emailed to senior clinical staff at point of entry into the system, ensuring prompt action and escalation to the CEO and notification to Healthcare Improvement Scotland. This ensures that appropriate and timely support is available to patient, family and staff members involved. Staff have access to a Clinical on call manager out of hours, who has the support of a senior on call manager for advice. All incidents are reviewed and closed by a senior member of the team to ensure any learning and identified improvements have been documented and implemented. The monthly Learning and Improvement meeting is a forum to discuss learning across the hospice

clinical services. We report to the Hospice Clinical Governance Committee regarding information relating to duty of candour on a quarterly basis.

Although no incident has taken place that has resulted in the duty being activated, our practice is that we are open and honest with patients and families, have a robust process around ensuring our policies and risk assessments are current and up to date, and that reflection and learning is at the centre of post incident staff discussions, for all clinical incidents.

Training and Support for staff

Principles of duty of candour are now routinely included in annual mandatory training sessions. All new staff have opportunities to access our electronic risk assessment and incident reporting system as part of their induction. All new senior clinicians and clinical managers complete duty of candour e-learning on appointment which is repeated every two years. We have a range of support available to staff following incidents.

Support for relevant persons

Where a relevant person (i.e. patients, families, etc.) is affected by the incident that activated the organisational duty of candour, we would provide them with range of options to support their wellbeing.

We hope you find this report useful.

Jackie Stone CEO

Date: 05.05.26