The 'Duty of Candour'

The Duty of Candour

The Duty of Candour is our legal responsibility to be open and transparent with individuals and their families when something goes wrong with their care. It is part of our commitment to placing the safety and needs of those we serve above everything else, to ensuring we learn from mistakes, and to improving our health and care services.

The Duty of Candour duty extends to all service areas and all staff who are involved in an individual's care. Hospice Duty of Candour policy is designed to support staff, patients, carers, relatives, and anyone affected by an adverse incident connected to one of our services to understand what the Duty of Candour means in practice for them.

The introduction of the Duty of Candour was one of the core recommendations of Sir Jonathan Michael's Independent Review of our health and social care system and became law as part of the Manx Care Act 2021.

Health and social care professionals already have a duty to be open and honest with patients when things go wrong. This duty is as described in the Professional Standards Authority for Health and Social Care Duty of Candour and joint General Medical Council and Nursing & Midwifery Council document.

Section 11 sub-section 2 of the Manx Care Act makes this also the responsibility of all organisations involved in health and social care on behalf of the Island (https://www.gov.im/media/1372267/duty-of-candour-operational-policy-v10.pdf)

The Act states:

'The Department must, by regulations, make provision as to the information to be provided by a relevant service provider in a case where an incident of a specified description, or a prescribed degree of severity, affecting a service user's safety occurs in the course of the service user being provided with a health service or a social care service.'

Our legal obligations

1. Duty of Candour Procedure

Further to this Act of Tynwald, the Manx Care (Duty of Candour Procedure) Regulations 2021 set out the regulations which apply to Manx Care/Hospice from 1st April 2021 in relation to upholding our the legal Duty of Candour

We recognise that providing health and care services and treatments involves a level of risk, and that is why the "informed consent" of service users is so important. However, the Duty of Candour reflects the need for us to be open and honest when something happens during the course of delivering care which is unintended and / or unexpected and causes harm to a service user.

This includes our responsibility to:

- inform the individual, or where appropriate, the person's advocate, carer or family when something has gone wrong
- apologise to them

- offer an appropriate remedy or support to put matters right (if possible)
- explain what has happened and understand the impact
- conduct a thorough review of the incident
- share the findings with those affected
- ensure any lessons are applied to improve the experience and outcomes of health and care services in the future.

Please note that the Duty of Candour does not stand alone and is part of our broader clinical and care governance systems, designed to support the improvement of our health and care system. This policy should be read in the context of our broader processes for managing serious incidents, complaints, and for driving improvement. (https://iomgov.sharepoint.com/:w:/r/sites/HospiceComms/)

Preparing the duty of candour procedure:

We will consider the following points when preparing the duty of candour procedure and annual report:

- How we will identify the incidents that trigger the Duty of Candour procedure, as outlined insection 11 sub-section 2 of the Manx Care Act 2021?
- Do Hospice staff understand their responsibilities, and do we have systems in place torespond effectively?
- Who do we need to engage with to satisfy ourselves we can meet the responsibilities of the Dutyand deliver the requirements outlined in the Act?
- What systems we have in place to support staff to provide an apology in a person-centred wayand how we support staff to enable them to do this?
- Do our current systems and processes provide the information required to report on the Duty of Candour?
- How we will align our duty of candour annual report with other reports we are required toprovide, such as feedback and complaints, significant events reviews, case reviews etc.?
- What training and education we have at present that will support the implementation of the Duty? This could be training that considers issues such as how to give an apology, being open, meetings with families, dealing with difficult situations. We also participate in national training which is available freely to our staff such as elearn vannin.
- What we have available for people involved in invoking the procedure (staff) and those affected(staff and service users)?
- How we currently share lessons learned and best practice around incidents of harm? Could thisbe improved in any way?

2. Duty of candour annual report

We will prepare a duty of candour report at the end of each financial year, providing information about when and where we have applied the duty of candour. The annual report will be reviewed by the Senior Leadership Team (SLT) before being submitted formally by the Hospice CEO to the Hospice Board. If requested it will be shared with the Manx Care Board and the Department of Health & Social Care.

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 triggered duty of Candour within our service.

Name & address of service:	Hospice Isle of Man, Strang, Braddan, Isle of Man. IM4 4RP
Date of report:	27/08/24 (Period 1 April 2023 – 27th August 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 values and attitudes of the Hospice team is underpinned by our Hospice Isle of Man Measured Ambition -Our three year Strategy 2024-2026 which is founded upon the principles of caring, working together, respect and professional. Staff are aware of the importance of candour through the development and implementation of Hospice Policy. Duty of Candour is discussed at the multi-disciplinary meetings, clinical governance and is incorporated into our adult and children safeguarding training. Duty of Candour underpins our communication with patients and families following every incident, whether it requires implementation or not. Staff complete the Duty of Candour module on elearn vannin which is completed on induction. We are currently 93% non-clinical and 99% clinical.
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 23 - August 24)
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?	N/A - there have been no instances of implementing Duty of Candour in any of the above-noted circumstances. All staff have a duty of candour and a professional responsibility to be honest and communicate effectively when things go wrong.
What lessons did you learn?	N/A - there are no incidents to report for this period. All staff are aware that following any incident, an immediate investigation is carried out by designated personnel, risk assessments are created and updated as appropriate and details, if appropriate are recorded on EMIS (our electronic clinical record) and added to the SBAR which is shared at each handover report.
What learning & improvements have been put in place as a result?	N/A – no incidents
Did this result is a change / update to your duty of candour policy / procedure?	N/A – no incidents Our current Duty of Candour policy is available in Hospice intranet.
How did you share lessons learned and who with?	Any lessons learned would be shared at staff team meetings, ward handovers, debrief sessions, multi-disciplinary meetings by way of a case study and education session (if appropriate). Any slips, trips and falls, including those which have not resulted in harm as defined under Duty of Candour would be discussed at staff team meetings.
Could any further improvements be made?	Not that we are aware of at present. Policy is reviewed and any changes in Manxcare policies/ law will be updated into Hospice policy
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?	In terms of our policy, senior members of staff take responsibility for ensuring any apology is delivered when necessary. Senior staff especially members of the SLT will support staff.
What support do you have available for people involved in invoking the procedure and those who might be affected?	All staff have access to Hospice policies in Hospice shared folder. SLT and senior staff are available to provide guidance/support to staff.
Please note anything else that you feel may be applicable to report.	Nothing at this time but we will continue to review, monitor and develop our policy.

27.08.24
Cheryl Young
Community Service Lead/ Nurse Consultant