# Policy Name: Duty of Candour

## Policy Number: 36

**Statutory Duty of Candour**

**Extract from the NHS Constitution for England 2009:** “…*when mistakes happen to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively”*

**Extract from CQC Regulation 20 : Duty of Candour:** *“The aim of this regulation is to ensure that health service bodies are open and transparent with the “relevant person” (as defined in the regulation) when certain incidents occur in relation to the care and treatment provided to people who use services in the carrying on of a regulated activity.”*

The Duty of Candour has been introduced as a direct result of the Francis Inquiry Report into the Mid Staffordshire NHS Foundation Trust, which recommended that a statutory “duty of candour” be imposed on all healthcare providers, which defined “Openness”, “Transparency” and “Candour”;

* **Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
* **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
* **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

The intention is that there is a culture of openness and truthfulness to improving the safety of patients, staff and visitors to the Practice, as well as raising the quality of healthcare systems. If patients or employees have suffered harm as a result of using their services, The Chorley Surgery should be able to confidently investigate, assess and if necessary apologise for and explain what has happened.

It is also intended to improve the levels of care, responsibility and communication between healthcare organisations and patients and/or their carers, staff and visitors and makes sure that openness, honesty and timeliness underpin responses to such incidents.

**Being Open**

A culture of “being open” is be fundamental in The Chorley Surgery’s relationships with (and between) patients, the public, Practice Staff and other healthcare organisations.

The Duty of Candour is the contractual requirement to ensure that the Being Open process is followed when an incident that affects patient safety results in moderate or severe harm, or death.

**“Being open” and “Duty of Candour”**

The Chorley Surgery will:

* Acknowledge, apologise and explain when things go wrong;
* Carry out investigations into incidents affecting Patient Safety;
* Provide support for those involved in the incident (patients and staff) to cope with the physical and emotional impact.
* Reassure patients, families and carers that lessons learned will prevent any patient safety incidents happening in future;

The ‘Being Open Framework’ provides guidance on how to ensure good communication with the patient, their families and carers.

**What is a Patient Safety Incident?**

The National Patient Safety Agency defines a Patient Safety Incident as: “Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care”.

**Recognising an Incident**

The relevance of the Duty of Candour begins with an acknowledgement that as the result of a safety incident, a patient has suffered moderate or major harm, or has died.

The Practice is not required by the regulation to inform a person using the service when a ‘near miss’ has occurred, and the incident has resulted in no harm to that person.

There must be appropriate arrangements in place to notify the person using the service who is affected by an incident if they are;

* **16 years and over** and
* **lack capacity to make a decision regarding their care or treatment** (as determined in accordance with sections 2 and 3 of the 2005 Mental Capacity Act)

this includes ensuring that a person acting lawfully on their behalf (e.g. persons acting as Carer) is notified as the relevant person.

A person acting lawfully on behalf of the person (e.g. persons acting as Carer) using the service must be notified as the relevant person where the person using the service is under 16 and not competent to make a decision regarding their care or treatment.

A person acting lawfully on behalf of the person (e.g. persons acting as Carer) using the service must be notified as the relevant person, upon the death of the person using the service.

Other than the situations outlined above, information should only be disclosed to family members or carers where the person using the service has given their express or implied consent.

**Process**

A step-by-step account of all relevant facts known about the incident at the time must be given, in person, by one or more appropriate representatives of The Chorley Surgery. This should include as much or as little information as the relevant person wants to know, be jargon free and explain any complicated terms.

The account of the facts must be given in a manner that the relevant person can understand. For example, The Chorley Surgery should consider whether interpreters, advocates, communication aids etc. should be used, while being conscious of any potential breaches of confidentiality in doing so.

As soon as an incident has occurred or been identified;

* Clinical care must be administered to prevent further harm.
* If any additional treatment is necessary, it should happen as soon as reasonably practicable after discussing with the patient (or carer if the patient is unable to participate in discussion) and with the appropriate consent.

Moderate / severe incidents, or any incidents that result in the death of a patient, must be reported to the patient or next of kin (with the appropriate consent) within a **maximum of 10 working days** from the incident being reported.

The initial notification of the incident must be verbal (face to face where possible), unless the patient/carer/family cannot be contacted or decline notification.

An explanation and a sincere expression of apology must be provided verbally and recorded. At the time of the incident, an initial apology and explanation must be given.

The Patient/Carer must be offered a written notification of the incident along with a sincere apology.

A step by step explanation of the incident must be offered as soon as it is practicably possible, even if this is an initial view pending investigation of the incident.

The Chorley Surgery will maintain full written documentation of any letters, discussions and meetings during this investigation, including the response from any of the patients/carers. If any meetings or interviews are offered and declined, then there will be a record of this.

Once the investigation has been completed and a final report has been made, the results should be shared with patient/relatives/carers within 10 working days.

All staff must have responsibility to adhere to that organisation’s policies and procedures around duty of candour, regardless of their level of seniority or whether they are permanent, temporary/casual members of staff.

The Chorley Surgery will give the relevant person all reasonable support necessary to help overcome the physical, psychological and emotional impact of the incident.

This could include all or some of the following:

* Treating them with respect, consideration and empathy.
* Offering the option of direct emotional support during the notifications, for example from a family member, a friend, a care professional or a trained advocate.
* Offering access to assistance with understanding what is being said e.g. via interpretative services, non-verbal communication aids, written information, Braille etc.
* Providing access to any necessary treatment and care to recover from or minimise the harm caused where appropriate.
* Providing the relevant person with details of specialist independent sources of practical advice and support or emotional support/counselling.
* Providing the relevant person with information about available impartial advocacy and support services, their local **Healthwatch** and other relevant support groups, for example **Cruse Bereavement Care and Action against Medical Accidents (AvMA)**, to help them deal with the outcome of the incident.
* Arranging for care and treatment to be delivered by another professional, team or provider if this is possible, should the relevant person wish.
* Providing support to access its complaints procedure.

**Definition of “Levels of Harm”**

**No harm**

* Impact prevented – any incident that had the **potential** to cause harm but was prevented and resulted in no harm to staff or patients.
* Impact not prevented - any incident that has occurred, but resulted in **no harm** to people receiving care.

**Low**

* An incident that required extra observation or minor treatment and caused **minimal harm**, to one or more persons receiving care.

**Moderate**

* An incident that resulted in a moderate increase in treatment (e.g. increase in length of hospital stay by 4-15 days) and which caused **significant but not permanent harm**, to one or more persons receiving NHS-funded care.

**Severe**

* An incident that appears to have resulted in **permanent harm** to one or more persons receiving care.

**Death**

* An incident that directly resulted in the death of one or more persons receiving care.

**A “Sincere Apology”**

The Francis Report indicated the importance of affected parties receiving a sincere apology for the impact that any incident can have on the patient, their families, next of kin and their carers, especially in incidents that cause severe harm or the loss of life. A meaningful apology for the incident or the circumstances that have led to the incident is an important part of coping with the effect that it has caused, and means that the Practice has taken these events (major or minor) seriously.

However, the Duty of Candour also states that an apology does not constitute an admission of liability. Patients and relatives will request detailed explanations of what led to the incident(s) occurring (and their adverse outcomes), and an apology and acknowledgement of the impact it has on them helps to understand that there are lessons that the Practice can learn to ensure this does not happen again in the future.

An apology is defined in the regulation as an expression of sorrow or regret. The NHS Litigation Authority has produced guidance on making an apology, which states that saying sorry is not an admission of legal liability.

In making a decision about who is most appropriate to provide the notification and/or apology, the Practice should consider seniority, relationship to the person using the service, and experience and expertise in the type of notifiable incident that has occurred.

**LMC**

The Local Medical Committee are able to support The Chorley Surgery and would provide support to obtain an independent view/obtain clinical input on individual circumstances. They will also offer individual support to a GPs and can speak to the GMC about a case without revealing the individuals involved.

**Appendix 1 : Actions and Timescales for Duty of Candour requirements**

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| **Requirement under Duty of Candour** | **Timeframe** |
| Patient or their family/carer informed that incident has occurred (moderate harm, severe harm or death) | **Maximum 10 working days** from incident being reported |
| A verbal notification of incident (preferably face-to-face where possible) unless patient or their family/carer decline notification or cannot be contacted in person.  A Sincere expression of apology must be provided verbally as part of this notification. | **Maximum 10 working days** from incident being reported |
| Offer of written notification made.  This must include a written sincere apology. | **Maximum 10 working days** from incident being reported  A record of this offer and apology must be made (regardless if it has been accepted or not) |
| Step-by-step explanation of the facts (in plain English) must be offered. | As soon as practicable  This can be an initial view, pending investigation, and stated as such to the receiver of the explanation. |
| Maintain full written documentation of any meetings. | No timeframe  If meetings are offered but declined this must be recorded. |
| Any new information that has arisen (whether during or after investigation) must be offered. | As soon as practicable |
| Share any incident investigation report (including action plans) in the approved format (Plain English) | **Within 10 working days** of report being signed off as complete and closed |
| Copies of any information shared with the patient to the commissioner, upon request. | As necessary |