# DUTY OF CANDOUR – Guidance for staff

## 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 was introduced in England 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, a Practice 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 underpins responses to such incidents.

## Being Open

A culture of "being open" should be fundamental in a Services relationships with Kingston GP Chambers patients, the public, Service 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.

## 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”.

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

Kingston GP Chambers will

- Acknowledge, apologise and explain when things go wrong;
- Open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity.
- Tell the relevant person (in person) as soon as reasonably practicable after becoming aware that a safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification.
- Provide an account of the incident which, to the best of the Service’s knowledge, is true of all the facts the Service knows about the incident as at the date of the notification
- Advise the relevant person what further enquiries the Service believes are appropriate.
- Give a timescale for the enquiries to be made and reported
- Carry out investigations into incidents affecting Patient Safety;
- Offer an apology.
- Follow up by providing the same information in writing, and any update on the investigations.
- Keep a written record of all communication with the relevant person.
- Provide support for those involved in the incident (patients and staff) to cope with the physical and emotional impact.
- Reassuring patients, families and carers that lessons learned will prevent any patient safety incidents happening in future;
- Report on any incident that falls under the CCG and CQC concerns at the earliest opportunity

**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 Service 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 Service can learn to ensure this does not happen again in the future.

## 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.

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 Service must maintain full written documentation of any letters, discussions, meetings during this investigation, including the response from any of the patients/carers. If any meetings or interviews are offered and declined, then there must 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.

**Notifiable safety incidents under Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20**

Notifiable safety incidents are specific types of incidents referred to under the Duty of Candour. In order to qualify as a notifiable safety incident the incident:

1. Must have been unintended or unexpected.

2. Must have occurred during the provision of a CQC regulated activity i.e. during the provision of care and treatment at one of our services.

3. In the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care. Moderate and severe harm is defined as:

    - the death of the person - directly due to the incident, rather than the natural course of the person's illness or underlying condition
    - the person experiencing a sensory, motor or intellectual impairment that has lasted, or is likely to last, for a continuous period of at least 28 days
    - changes to the structure of the person's body
    - the person experiencing prolonged pain or prolonged psychological harm, or
    - a shorter life expectancy for the person using the service.

If these criteria are met then the regulation requires healthcare providers to:

- Notify the person involved that the incident has occurred
- Provide reasonable support to that person

The notification must:

a. be given **in person** by one or more representatives of the registered person,

b. provide an account, which to the best of the registered person's knowledge is true, of all the facts the registered person knows about the incident as at the date of the notification,

c. advise the relevant person what further enquiries into the incident the registered person believes are appropriate,

d. include an apology, and

e. be recorded in a written record which is kept securely by the registered person.

Following this we need to provide a **written notification** to the person involved in the incident which includes:

a. all of the information provided in the in person notification above.

b. details of any enquiries to be undertaken to investigate the incident as outlined in the in person notification.

c. the results of any further enquiries into the incident, and

d. an apology.

In the event that the person affected by the incident cannot be contacted on declines to discuss the incident, records of attempted contacts should be maintained.

**Resources**

- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Regulation 20: Duty of candour - Care Quality Commission (cqc.org.uk)
- The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015
- Health Professional Council – legal framework
- Mental Capacity Act 2005
- Mental Capacity Act Code of Practice

**Actions and Timescales for Duty of Candour requirements**

| 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.<br><br>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.<br>This must include a written sincere apology. | **Maximum 10 working days** from incident being reported<br><br>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<br><br>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<br><br>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 |