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DUTY OF CANDOUR POLICY

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Introduction

1 Policy statement

The Wellington Practice will fulfil its obligations to satisfy its duty of candour. The CQC document titled [Learning, candour and accountability](#) states that all health and social care providers, including NHS trusts, are required to be “open and transparent with the people who use their services when there are notifiable safety incidents. This means incidents that are categorised as death, moderate harm, severe harm or prolonged psychological harm.”

This is a statutory requirement under [Regulation 20 of the Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2014](#).

This policy sets out the way in which The Wellington Practice will comply with its obligations and what individuals’ responsibilities are in relation to raising any concerns that they have and how those concerns will be dealt with.

The intention is that there is a culture of openness and honesty to improve the safety of patients, staff and visitors to The Wellington Practice as well as raising the quality of healthcare systems. If patients or employees have suffered harm as a result of using our services, the organisation will 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 make sure that openness, honesty and timeliness underpin our responses to such incidents.

2 Principles

Speaking up about any concern you have at work is important. This is, in fact, vital because it will help the organisation to continue to improve its services for all patients and the working environment for staff.

The [GMC](#) advises that when considering duty of candour, 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.

This means that healthcare professionals must:

- Tell the patient (or, where appropriate, the patient’s advocate, carer or family) when something has gone wrong
- Apologise to the patient (or, where appropriate, the patient’s advocate, carer or family)
- Offer an appropriate remedy or support to put matters right (if possible)
- Explain fully to the patient (or, where appropriate, the patient’s advocate, carer or family) the short- and long-term effects of what has happened.

The organisation is committed to an open and honest culture and we will aim to ensure to be open and transparent with those who use our services and other ‘relevant persons’ (people acting lawfully on their behalf) in general in relation to care and treatment.

We will investigate what is said and we will ensure that those who have concerns have access to the support they need. We are committed to listening to concerns, learning lessons and improving patient care.

3 Status

The organisation aims to design and implement policies and procedures that meet the diverse needs of our service and workforce, ensuring that none are placed at a disadvantage over others, in accordance with the [Equality Act 2010 \(as amended 2015\)](#). Consideration has been given to the impact this policy might have with regard to the individual protected characteristics of those to whom it applies.

This document and any procedures contained within it are non-contractual and may be modified or withdrawn at any time. For the avoidance of doubt, it does not form part of your contract of employment.

4 Training and support

The organisation will provide guidance and support to help those to whom it applies to understand their rights and responsibilities under this policy. Additional support will be provided to managers and supervisors to enable them to deal more effectively with matters arising from this policy.

A short YouTube clip entitled [Training Video Duty of Candour](#) can support staff training in this area.

5 Scope

5.1 Who it applies to

This document applies to all employees of the organisation and other individuals performing functions in relation to the organisation such as agency workers, locums and contractors.

Furthermore, it applies to clinicians who may or may not be employed by the organisation but who are working under the Additional Roles Reimbursement Scheme (ARRS).¹

5.2 Why and how it applies to them

A culture of 'being open' is fundamental in the organisation's relationships with (and between) patients, the public, organisation staff and other healthcare organisations.

The duty of candour is a statutory duty to be open and honest with patients (or 'service users') or their families when an incident that affects patient safety results in, or could lead in the future to, moderate or severe harm or death.

Everyone should be aware of the importance of preventing and eliminating patient safety incidents at work. All members of staff should be watchful and report anything of that nature of which they become aware.

¹ [Network DES Contract specification 2021/22](#)

Any matter raised under this procedure will be investigated thoroughly, promptly and confidentially and, in most circumstances, the outcome of the investigation made known to all staff.

Any employee who raises a concern (or makes a protected disclosure or 'blows the whistle') has the right not to be dismissed, subjected to any other detriment or victimised because they have made a disclosure. This means that the member of staff's continued employment and opportunities for future promotion or training will not be prejudiced because they have raised a legitimate concern. Victimisation of a worker for raising a qualified disclosure is a disciplinary offence.

Further reading can be sought in the [Whistleblowing policy](#).

6 Definition of terms

6.1 Duty of candour

The CQC document titled: [The duty of candour: guidance for providers](#) explains the requirements in detail including providing supporting examples for the different areas of healthcare provision and alludes to [Regulation 20: Duty of Candour](#) that provides the legal basis that relates to this subject.

Both the statutory duty of candour and professional duty of candour have similar aims. These are to make sure that those providing care are open and transparent with the people using their services whether or not something has gone wrong.

In interpreting the regulation on the duty of candour, the CQC uses the definitions of openness, transparency and candour used in the Sir Robert Francis QC [report](#) into the public enquiry of the Mid Staffordshire NHS Foundation Trust.

6.2 Openness

Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

6.3 Transparency

Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

6.4 Candour

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.

6.5 Patient safety ²

The NHS England definition of patient safety is:

“Patient safety is the avoidance of unintended or unexpected harm to people during the provision of healthcare. We support providers to minimise patient safety incidents and drive improvements in safety and quality. Patients should be treated in a safe environment and protected from avoidable harm”.

² [NHS England Patient Safety](#)

7 Event reporting

The NHS Learning from Patient Safety Events (LFPSE) Service was established in July 2021 and will ultimately replace the NHS National Reporting and Learning System (NRLS). In the interim period, NRLS remains the central database of patient safety incident reports.

8 Degrees of harm

NRLS has published a document that defines the [degrees of harm](#) which details these as follows:

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 person's receiving care

Moderate: An incident that resulted in a moderate increase in treatment (e.g., an increase in the length of a hospital stay by 4-15 days) and which caused significant but not permanent harm to one or more person's receiving care

Severe: An incident that appears to have resulted in permanent harm to one or more person's receiving care

Death: An incident that directly resulted in the death of one or more person's receiving care

9 Procedure

9.1 Recognising an incident

The relevance of the duty of candour begins with an acknowledgement by a member of staff that an incident has occurred as the result of a safety incident and that a patient has suffered a degree of harm as outlined in [Section 3.7](#) above. The immediate actions to be taken as soon as an incident has occurred or been identified are:

- Administer clinical care to prevent further immediate harm
- Arrange for any follow up treatment, if necessary, as soon as reasonably practicable after discussing with the patient (or carer if the patient is unable to participate in the discussion) and with the appropriate consent
- Consider reporting the incident as outlined in the [Significant Event and Incident Policy](#) to the Care Quality Commission (CQC) or NRLS/LFPSE

The CQC's guidance, under the heading *Illustrative examples for general practice which trigger the thresholds for duty of candour* are given in [GP Mythbuster No 32: Duty of Candour and General Practice \(regulation 20\)](#).

9.2 A 'sincere apology'

The Francis Inquiry 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 will demonstrate that the organisation has taken events seriously, be they major or minor.

An apology under the duty of candour does not constitute an admission of liability. Patients and relatives are to be offered detailed explanations of what led to the incident(s) occurring and their outcomes as well as a sincere apology and acknowledgement of the impact it has had on them. This helps them to understand that there are lessons that the organisation can learn to ensure this does not happen again in the future.

CQC have provided [guidance](#) for providers that states that saying sorry is not admitting fault, nor any admission of liability, but it is a crucial part of our duty of candour.

To fulfil the duty of candour, this organisation will apologise for the harm caused, regardless of fault, as well as being open and transparent about what has happened.

9.3 Indemnity cover and litigation

NHS Resolution is the organisation that manages clinical negligence claims against the NHS and advises in their [Saying Sorry](#) leaflet that apologising will not affect indemnity cover:

They advise that saying sorry is:

- Always the right thing to do
- Not an admission of liability
- Acknowledges that something could have gone better
- The first step to learning from what happened and preventing it recurring

The CQC document titled [Learning, candour and accountability](#) shows that in many cases it is the lack of a timely apology that pushes people to take legal action.

10 Required actions and timeframes under the duty of candour

Requirement under duty of candour	Timeframe
Patient or their family/carer informed that an incident has occurred (moderate harm, severe harm or death)	Maximum 10 working days from incident being reported
An oral notification of the incident (preferably face-to-face where possible) unless patient or their family/carer decline notification or cannot be contacted in person	Maximum 10 working days from incident being reported

A sincere expression of apology must be provided verbally as part of this notification	
Offer of a written notification to be 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

11 Requirements related to meeting CQC Regulation 20

The CQC explains the requirements within its publication, Regulation 20: Duty of candour. Briefly they can be summarised as follows:

- Be open and transparent with the relevant persons in relation to the 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 organisation's knowledge, is true of all the facts the organisation knows about the incident as at the date of the notification
- Advise the relevant person what further enquiries the organisation believes are appropriate
- Offer an apology

- Follow up by providing the same information in writing and any update on the investigations. A sample follow-up letter following a face-to-face notification of a patient safety incident (PSI) under duty of candour is shown at [Annex A](#)
- Keep a written record of all communication with the relevant person

12 Reporting an incident to the authorities

It is important, depending on the degree of harm as outlined in [Section 3.7](#), to consider reporting the incident to the following:

- Commissioner/Clinical Commissioning Group (CCG) depending on the degree of harm as specified in their requirements
- Care Quality Commission
- National Reporting and Learning System (NRLS) and/or Learning from Patient Safety Events (LFPSE) Service

13 CQC inspections

Any information relating to the duty of candour will be investigated in line with both the CQC and the organisation's [safeguarding](#) and [whistleblowing](#) protocols.

14 Summary

By following the procedures required under a duty of candour as outlined in this policy, The Wellington Practice will ensure that it meets the requirements expected of it not only by the CQC but by its patients.

Patients have a right to be treated in a safe environment and protected from avoidable harm. By frankly admitting any errors involving patient safety which could lead to any degree harm, the organisation should enhance the reputation that it has a culture of being open and honest with patients.

By being aware of the importance of preventing and eliminating patient safety incidents at work and reporting anything of that nature of which they become aware, employees will be fulfilling their duties and responsibilities under the duty of candour.

In addition, all employees, partners and directors are also reminded that any matter raised under this procedure will be investigated thoroughly, promptly and confidentially and, in most circumstances, any outcome of the investigation will be made known to all staff.

15 Annex A: Information to support a sample letter

The sample text shown below may be used in a letter following a notification being given in person to a patient (relevant person) and/or their relative of a patient safety incident/event.

This is in accordance with the organisation's (registered person) obligations under the duty of candour. See below relevant components of Regulation 20.

a. Component 20 (2)

When a notifiable safety incident has occurred, the relevant person must be informed in person as soon as reasonably practicable after the incident has been identified.

For NHS Contract holders, there is a requirement for the notification to be made in person within 10 working days of the incident being reported.

b. Component 20(4)

A written notification must be given or sent following the initial meeting even though the enquiries may not yet be complete. This written notification must contain:

- All the relevant information that was provided in person at the initial notification meeting
- An apology
- Results of any enquiry made since the initial notification meeting was given in person
- The outcomes or results of any further enquiries and investigations must also be provided in writing to the relevant person through further written notifications if they wish to receive them

c. Component 20(5)

If the relevant person cannot be contacted in person or declines to speak to the representative of the registered person, a written record is to be kept of attempts to contact or speak to the relevant person.

The provider must make every reasonable attempt to contact the relevant person through all available means of communication.

d. Component 20(6)

The registered provider must keep a copy of all correspondence with the relevant person under component 20(4).

If in any doubt, seek advice from NHS Resolutions / MDDUS / MDU as appropriate in regards to the content of the letter and how in-depth this should be.

Annex B: Sample letter

[Insert patient's or carer's name and address along with date and reference number of the letter as per organisation house style].

Dear (patient/relative)

Following our initial meeting which took place on [insert date] to inform you of a notifiable safety incident under the statutory duty of candour, I am writing to provide you/your [identify relationship, e.g., husband, wife, etc.] with all the relevant information that was provided at that initial face-to-face meeting.

As explained at the initial face-to-face meeting, we investigated this event and explained our findings to you as follows [insert details of findings].

*Delete if not applicable

[As explained at the initial meeting, we stated that we were undertaking further enquiries and when these are completed, we will inform you of the outcome.]

OR

[As explained at our initial meeting, we stated that we were undertaking further enquiries and these have been completed and the outcome of these are as follows.]

Please find enclosed a leaflet detailing the duty of candour. This has been created by an organisation called AvMA and has been endorsed by the Care Quality Commission.

<https://www.avma.org.uk/policy-campaigns/duty-of-candour/duty-of-candour-leaflet/>

We would like to express our sincere apologies that this event has occurred as the organisation aims to provide the good, high-quality services that our patients expect.

Yours sincerely

For and on behalf of The Wellington Practice