
# Policy on Duty of Candour

# Statutory Duty of Candour

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.*

In March 2016, legislation was passed by the Scottish Parliament including laws relating to a statutory Duty of Candour. This places a responsibility on health and social care organisations to be open and transparent in dealing with instances where a patient has suffered unintended harm, either physical or mental, during a period of treatment or care.

The provisions required by the Bill include the need for all organisations subject to the duty to submit and publish an annual report. This must include details of the number and nature of any incidents; an assessment of the extent to which the responsible person carried out the duty; information about policies and procedures; any changes to policy and procedure as a result of incidents to which the duty has applied; and any other information the responsible thinks fit to include.

The Duty of Candour provisions in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill were given Royal Assent on April 6, 2016. It came into force on 1 April 2018.

The purpose of the Duty of Candour provisions is to support the implementation of consistent responses across health and social care providers when there has been an unexpected event or incident that has resulted in death or harm, which is not related to the course of the condition for which the person is receiving care.

**Practice Responsibility**

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 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.

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 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.

**Being Open**

A culture of “being open” should be fundamental in a Practice’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.

**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.

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 Practice must 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 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.

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

Station Road Medical Practice must:

* Be open and transparent with relevant persons in relation to care and treatment provided.
* Acknowledge, apologise and explain when things go wrong.
* Carry out investigations into incidents affecting Patient Safety.
* Provide an account of the incident which, to the best of the Practice’s knowledge, is true of all the facts the Practice knows about the incident as at the date of the notification.
* Offer an apology.
* 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 at the earliest opportunity.
* Keep a written record of all communication with the relevant person.

**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 Harm

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

Moderate Harm

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 Harm

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.

**Practice Contacts**

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**Resources**

<http://www.gov.scot/Topics/Health/Policy/Duty-of-Candour>

**Appendix: 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. |