# Duty of candour policy

**Version 4.0**

## Summary

This policy outlines the process to follow to meet the requirement to be open and honest when an incident results in moderate or severe harm.

## Supporting documents

- Incidents management policy
- Complaints management policy
- Freedom to Speak Up/Whistleblowing policy
- Confidentiality policy
- Information Governance Charter
- Risk management policy
- Blame-free culture policy
- CQC notifiable events policy
- Disciplinary policy and process

## Date issued:

Oct-17

**Next Review Date:**

Sep-21

Approved & Ratified by:

Integrated Governance and Quality Committee (IGQC)

**Date ratified:**

Sep-19

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**Owner:**

Dr Angelique Edwards – Medical Director, Chair

## Version Control

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1. Introduction

All healthcare professionals have a professional duty of candour – a professional responsibility to be honest with patients when things go wrong. All moderate, severe harm and death incidents meet the statutory duty of candour requirements.

The statutory duty of candour places a responsibility on providers to ensure communication with anyone involved in an incident of this level is open, honest and occurs as soon as possible following an incident and the following will apply:

Be honest and supportive - Tell the relevant person directly as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred and provide support to them in relation to the incident, including when giving the notification.

Be open - Provide an account of the incident which, to the best of our knowledge, is true of all the facts we know about the incident as at the date of the notification.

Investigate - Advise the relevant person what further enquiries we believe are appropriate.

Apologise - Offer an apology.

Write a letter - Follow this up by giving the same information in writing and providing an update on the enquiries.

Keep records - Keep a written record of all communication with the relevant person.

This policy provides a framework for:
• Open, accurate and timely communication, apology and support to patients, relatives and staff
• Staff to be encouraged to report incidents
• For the organisation to learn from errors through root cause analysis and investigation

2. Scope of the Policy

This policy is for all BHIC staff including anyone providing directly contracted services. It relates to incidents that result in moderate or severe harm. Incidents graded as no or low harm do not meet the duty of candour requirement. However, there may be circumstances in which no or low harm incidents would be appropriate to be communicated to the patient and/or their carer.

The benefits and problems associated with communicating with patients and/or their carers about no or low harm incidents should be discussed with the Medical Director and will depend on the circumstances.

3. Definitions

Being open/ openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

Candour – frankness and honesty. Any patient harmed by the provision of healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked.
Duty of candour - the legal obligation requiring health providers to be open and honest with patients and provide support when incidents occur in relation to their care and treatment which cause moderate, severe harm or result in death.

Near miss/ potential harm - any unexpected or unintended occurrence or incident that did not lead to harm, loss or damage, but had serious potential to do so and was prevented either by intervention or luck.

No harm – no injuries or obvious harm. No loss of property. No significant likelihood of service issues arising from incident.

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

Moderate harm – any incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm.

Severe harm – a permanent lessening of bodily, sensory, motor, physiologic or intellectual function, that is related directly to the incident and not related to the natural course of the service user’s illness or underlying condition.

Catastrophic or death – any incident that directly resulted in the death of one or more persons receiving NHS funded care. Death must be related to the incident rather than the underlying condition or illness.

Notifiable safety incident- any incident which results in or appears to have resulted in moderate or severe harm, or death.

Transparency - allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. (Francis 2013)

4. Duties and responsibilities

Chief Executive - The Chief Executive is responsible for ensuring that there are effective arrangements for being open and meeting the Duty of candour requirements within BHCIC.

Medical Director - Provides clinical leadership and will ensure that advice; training and support mechanisms are in place for staff in respect of the management of patient safety incidents and the process of being open with patients. The Medical Director is responsible for ensuring that the patient and their families have been informed when things have gone wrong and supporting open communication between staff, patients, families and carers.

Head of Clinical Services and Clinical Governance - To promote a culture that ensures overall implementation of this document supported, where appropriate, by the Medical Director.

Clinical Leads/ Heads of Department - The Clinical Leads / Heads of Department support the local teams in discovering the circumstances of the incident and ensure that appropriate discussions with patient/carers have taken or will take place and are recorded appropriately. Through the clinical areas they will promote the Duty of Candour policy to all staff and ensure they access relevant training if required. They must be informed of all incidents that result in major or catastrophic harm, and that patients / or carers have been informed.
Healthcare Professionals - All healthcare professionals including temporary staff should be aware of their own professional duty of candour and the duty of candour policy. They must be aware of the need to report, inform and discuss adverse events with the patient/ carers, in line with this policy.

All staff - All staff and volunteers have a responsibility for ensuring that patient safety incidents are acknowledged and reported as soon as they are identified.

Any member of staff, who believes that a colleague is not following this policy after an incident, should discuss this with their line-manager. Failure to follow this policy could lead to action being taken in accordance with the Disciplinary Policy and may also result in referral to the relevant regulatory body.

5. Immediate steps

The Duty of candour applies to incidents that occur during the provision of care. Once a notifiable safety incident (i.e.an incident that resulted in moderate, severe, significant or prolonged psychological harm or death) has been identified the statutory duty of candour requirement, must be followed.

- The incident must be recorded
- The patient/ person affected must be informed and reasonable support in relation to the incident must be offered.
- The initial discussion should be face to face and occur as soon as possible after the incident.
- A discussion with the team should establish:
  - Basic clinical facts
  - An assessment of the incident
  - Level of immediate response required – NB: where necessary immediate clinical care should be given to prevent further harm
  - The type of support required for the patient
  - Support required for staff involved
  - Clear communication plan
  - Possible team members who could conduct discussion with patient/relative/carer

- Generally, the most senior person responsible for the patient’s care should lead on communicating with the patient. This should be someone who:
  - Has a good understanding of the relevant facts
  - Be sufficiently senior and have sufficient experience and expertise in relation to incidents and communicating with people affected
  - Has excellent interpersonal skills, including being able to communicate with patients in a way they can understand, being compassionate and supportive
  - Be willing and able to offer an apology, reassurance and feedback
  - Be able to maintain a relationship with the patient and to provide continued support and information
  - Be culturally aware and informed about the specific needs of the patient
  - Have a good relationship with the patient (if there has been prior contact)

- When communicating with the patient about the incident it must:
  - Be done in person by one or more staff, including where possible the senior clinician responsible for the patient
  - Provide an account, which to the best of knowledge is true, of all the facts known about the incident
Inform the patient what further enquiries and investigations into the incident are appropriate;
Include an apology - this must be a meaningful and sincere expression of regret or sorrow for what has happened to the patient;
Give time for questions
Agree with the patient any future meetings as appropriate
Provide a point of contact for the patient
Be recorded in a written record which is kept securely

The patient must be treated with compassion, respect and empathy and offered appropriate emotional and practical support e.g. they may wish to have a friend or relative present during discussions or may need communication aids (interpreter, braille etc.). Information should also be provided about independent sources of advice and support or counselling.

If for any reason it becomes clear during initial discussions that the patient would prefer to speak to a different healthcare professional the patient’s wishes should be respected and a substitute with whom the patient is more comfortable should be provided.

Patients have the right to expect that their care will continue, and that they will receive all their usual treatment with the care, respect and dignity that they are entitled to. If the patient requests that their care be delivered by another team, this should be respected, and the appropriate arrangements should be made. The patient may also require support to make a complaint and be guided through that process.

If the patient lacks mental capacity the person acting lawfully on behalf of the patient (e.g. someone with lasting power of attorney (LPA), should be notified in accordance with this procedure. If there is no LPA for the patient, it is best practice that the family and/or carers are notified.

All reasonable attempts to contact the person through available communication channels must be made. If contact cannot be made with the patient, or they decline to speak to BHCIC or are deceased, a written record must be kept of this and of all communication attempts.

6. After the initial meeting

The initial meeting to inform the patient must be followed by one or more written notifications given or sent to the patient containing:
• The information provided at the meeting
• Details of any enquiries and investigations to be undertaken
• Details of any enquiries and investigations that have already been carried out into the incident, and any causes of that incident, or other findings, that have been identified as a result
• Any steps that have been taken to prevent the recurrence of the incident
• An apology
• Invitation to participate in the investigation
• Process and timescales agreed for keeping the patient up to date
• Questions asked and answers provided
• Offer of practical and emotional support

A copy of all correspondence with the patient and full written records of any meeting(s) or other contact with the patient in relation to the incident must be kept securely.

All written notification must be in the form of the standard letter template and must be approved by the Medical Director and Chief Executive.
7. Investigation

A full investigation must be undertaken in line with the Incident management policy. It is good practice to inform the patient about who will be involved in the investigation and give them opportunity to raise any objections. A written report must be prepared and approved by the Medical Director and the Chief Executive.

It will be necessary to keep in mind that the report will be a public document that will be shared. The report should be factual and use appropriate language, avoiding inaccessible/medical terminology. Consideration should also be given to using generic terms/job titles (e.g. the patient, the clinician) or initials rather than full names.

Within **10 working days** of the investigation the patient must be provided with a copy of the investigation report. The report should include:

- The outcome of the investigation
- Details of the patient’s concerns and complaints
- The chronology of clinical and other relevant facts
- A repeated apology for the harm caused to the patient from the incident
- A summary of the factors that contributed to the incident (how and why the incident occurred)
- Details on what has been and will be done to avoid recurrence of the incident and how improvements will be implemented and monitored

The patient should also be offered a resolution meeting with the most senior clinician involved in their care or, if appropriate, the Medical Director and/or the Chief Executive.

8. Reporting the incident to other bodies

It is likely that the incident will be categorised as a Serious Incident. Depending on the type of incident and the level of harm caused to the individual it will be necessary to consider the need to report the incident to:

- The patient’s own GP
- Clinical Commissioning Group (CCG)
- Care Quality Commission (CQC)
- Health & Safety Executive (HSE)
- Police
- Coroner

When providing the patient (or their family) with a copy of the investigation report, they must be informed that it will be shared with other bodies as part of the duty of candour requirement.

9. Staff support

The investigation into a patient safety incident/complaint or claim should be focused on systems and processes, rather than individuals.

Being involved in an incident, complaint or claim which is under investigation can be a stressful experience. BHICIC will endeavour to supports patients, carers, relatives and staff through a number of support mechanisms.

Directors should:
• Ensure that the appropriate support is offered to all staff in the event of an incident, be they potential victims, witnesses, those accused or investigators.
• Ensure that risk assessments are undertaken that consider mental and psychological hazards and that suitable control measures to reduce risk and support vulnerable staff are put into place.
• Ensure that good human resource and management practice is adopted.

Clinical Leads should:
• Carry out risk assessments to determine mental and psychological hazards as a result of involvement with a traumatic incident, complaint or claim.
• Ensure that good human resource management practice is adopted.
• Deal sensitively and effectively with staff reporting symptoms or feelings that could be stress related because of such an event.

Individual staff members must:
• Bring to their line manager’s attention if they feel they cannot cope with the pressures and demands of work placed upon them as a result of a traumatic incident, complaint or claim.
• Participate fully in the risk assessment process and observe any control measures introduced as a result of the risk assessment.

Immediate and ongoing support offered to staff is available through several sources and staff members are informed at the time of induction of the support available:
• Occupational Health Services provided by Peninsula (free 24-hour helpline 0800 047 4097) which provides confidential and impartial advice to staff on all aspects of the relationship between work and health including counselling.
• Trade Union/ staff organisations.
• Freedom to Speak Up/ Whistleblowing policy
• NHS Whistle-blowers Helpline (0800 072 4725)

Ongoing monitoring of the effectiveness of supporting staff is achieved in a number of ways including the review of:
• Sickness absence returns
• Turnover rates
• Exit interviews
• Accidents at work
• Reports of bullying/ harassment/ grievances
• Staff surveys
• Occupational health reporting
• Communications received under Freedom to Speak Up/ Whistleblowing

10. Policy Review
This policy will be reviewed every two years.

11. Distribution
This policy will be implemented and disseminated through the organisation immediately following ratification.
12. Equality and Diversity Assessment

This policy has been reviewed against our Equality and Diversity assessment:

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<td>Can we reduce the impact by taking different action?</td>
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If you have identified a potential discriminatory impact of this procedural document, please speak with your line manager with any suggestions as to the action required to avoid/reduce this impact.
13. Appendix 1 Being Open/ Duty of Candour –Guide and points to consider

Anyone involved in the process needs to read and use these practical guidelines and see https://improvement.nhs.uk/resources/learning-from-patient-safety-incidents/ for further information.

Communication

Open and effective communication with the patient and family is likely to include the following aspects:

- Early on identify and seek to meet patient’s practical and emotional needs e.g. the names of people who can provide assistance and support to the patient (patient’s consent would be required before information can be given).
- Any special restrictions on openness that the patient would like the healthcare team to respect.
- Identifying whether the patient wants to know every aspect of what went wrong. If they do not, respect their wishes and reassure them that this information will be made available later on should they change their mind.
- Provide repeated opportunities for the patient and family to ask for information about the incident.
- Provide information in written and verbal form.
- Provide assurance that an ongoing care plan will be formulated with the patient.
- Facilitate inclusion of the patient’s family in discussions, if the patient wishes.
- Information may need to be given more than once and at different times to allow the patient and family to understand.
- Ensure the patient’s account of events leading up to the incident is fed into the incident investigation.
- Provide information on how improvements will be made as a result of learning from the incident.

Before the meeting

Preliminary multi-disciplinary team discussion should be held as soon as possible after the event, including the most senior health professional involved.

- Basic plans should be made about who does what and how patients’ needs will be met.
- The timing of the Being Open discussion should be planned, holding it as soon as possible after the incident whilst considering relevant factors.
- An appropriate individual should be chosen to communicate with patients/carers and inform them about the incident.
- This should be the most senior person responsible for the patient’s care and/or someone with appropriate experience and expertise.
- They should have the training and skills needed and be acceptable to those involved.
- A substitute for the most senior person involved should only be used exceptionally and that person must have the required skills and information.
- The healthcare professional conducting the discussion should be able to nominate a colleague to assist them with the meeting.
- If it is clear the patient would rather speak to someone else, a substitute should be provided. Normally, junior health care professionals should not lead the Being Open process.
- If they ask to be involved, they should be accompanied and supported by a senior team member.
• Where the incident relates to the environment of care (e.g. an injury), a senior manager of the relevant service should communicate with the patient/carers.
• The discussion should include a senior member of the multidisciplinary team and the healthcare professional responsible for treating the patient.
• Regarding incidents arising from errors by healthcare staff, the involvement of the staff involved must be considered individually balancing the needs of the patient/carers with those of the healthcare professional concerned.
• Guidelines are given on meeting both sets of needs and the use of written apologies.
• The incident must be reported via the Battersea Healthcare incident reporting system and the National Reporting and Learning System (NRLS).
• The patient’s General Practitioner should be informed by the Consultant or identified clinical lead.
• The coroner should be informed of all cases of untimely, unexpected or unexplained death and suspected unnatural death. Involvement of the coroner should not prevent apologies where appropriate.
• Other statutory bodies may need to be informed.

The meeting

The Being Open discussion should include:
• Those involved.
• Expressions of sympathy or regret or apologies.
• Handling the facts and when disagreement about them occurs.
• Understanding and noting the views of patients and carers.
• Appropriate language and terminology.
• Explaining what happens next in terms of treatment plan and incident analysis findings.
• Information on effects of the incident.
• Offering practical and emotional support.
• Recognising that patients/carers may be angry or frustrated.
• Avoiding speculation, attribution of blame, denial of responsibility and conflicting information.
• Arrangements for subsequent discussions.
• Copy of investigation report may be offered once available.

Documentation

All staff managing Duty of Candour meetings must be aware of the following document:
• Copy of incident report or complaint and root cause analysis investigation report
• A written record of all Duty of Candour discussions/meetings is made in the health records
• Being Open – Duty of Candour meeting – heading in health records
• Date, time, place, date and name and relationships of all attendees
• Plan for providing further information to patient and family
• Offers of assistance and the patient’s and family’s response
• Questions raised by the patient and family/issues for consideration in the investigation
• Plans for follow up meetings
• Progress notes relating to the clinical situation and an accurate summary of all the points explained to the patient and family
• Copies of letters sent to the patient and family and the GP for patient safety incidents not occurring in primary care.
• Written record of the discussions (a summary should be shared with the patient).
Preliminary Follow-Up

Follow-up discussions should be planned, carried out and recorded. These should occur at the earliest practicable opportunity.

Completing the Process

- Feedback – this should be given in a form acceptable to the patient after completion of the incident investigation, usually through discussion.
- Communication should include a chronology, details of concerns and complaints, apology and any shortcomings, factors that contributed and what has been and will be done to prevent recurrence, with monitoring arrangements.
- Arrangements for continuity of care need to be made and information given to patients on their clinical management plan.
- Reassurance should be given that the dispute will not affect their care and their right to continue their treatment elsewhere.
- Communication with the GP and other community care service providers is required including a description of the implications of the incident.
- Changes as a result of learning must be communicated with staff. This is a vital step to prevent recurrence.
### 14. References

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