

**Protocol:** Duty of Candour Policy  
**Agreed By:** The Partners of Cloister Road Surgery  
**Reviewed:** Annually  
**Latest review date:** 24 June 2019 (SD)

## Cloister Road Surgery

# DUTY OF CANDOUR POLICY

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## **1 Introduction**

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### **1.1 Policy statement**

Cloister Road Surgery will fulfill its obligations to satisfy the “statutory duty of candour” as outlined below.

This policy sets out the way in which the Practice will comply with its obligations and what the individual 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 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 our services, the Practice 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 makes sure that openness, honesty and timeliness underpin our responses to such incidents.

### **1.2 Principles**

Speaking up about any concern you have at work is important. In fact, it’s vital because it will help the Practice to keep improving its services for all patients and the working environment for staff.

Raising concerns can sometimes feel like ‘complaining’ or going behind others’ backs and this can sometimes prevent people from speaking up, but please don’t be put off. The Practice is committed to an open and honest culture, we will investigate what you say, and we will ensure you have access to the support you need.

We are committed to listening to our staff, learning lessons and improving patient care. Remember that if you are a healthcare professional you may have a professional duty to report a concern. If in doubt, please raise it.

### **1.3 Status**

The Practice 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. Consideration

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has been given to the impact this policy might have in respect 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.

## **1.4 Training and support**

The Practice will provide guidance and support to help those to whom it applies 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.

## **2 Scope**

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### **2.1 Who it applies to**

This document applies to all employees, Partners and directors of the Practice. Other individuals performing functions in relation to the Practice, such as agency workers, locums and contractors, are encouraged to use it.

### **2.2 Why and how it applies to you**

A culture of “being open” is fundamental in the 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.

Everyone should be aware of the importance of preventing and eliminating patient safety incidents at work. You should be watchful and report anything of that nature that you become aware of.

Any matter raised under this procedure will be investigated thoroughly, promptly and confidentially, and in most circumstances the outcome of the investigation will be reported back to you, as you raised the issue.

Remember also, an 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 you have made a disclosure. This means that your continued employment and opportunities for future promotion or training will not

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be prejudiced because you have raised a legitimate concern. Victimisation of a worker for raising a qualified disclosure will be a disciplinary offence.

### **3 Definition of terms**

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#### **3.1 Duty of Candour**

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”.

#### **3.2 Openness**

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

#### **3.3 Transparency**

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

#### **3.4 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.

#### **3.5 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”.

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### 3.6 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.

### 3.7 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.

## 4 Procedure

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### 4.1 Meeting CQC Regulation 20

To meet the requirements of CQC Regulation 20, the Practice will:

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- Be open and transparent 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 Practice's knowledge, is true of all the facts the Practice knows about the incident as at the date of the notification.
- Advise the relevant person what further enquiries the Practice believes are appropriate.
- 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.

#### **4.2 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.

It is recommended the following are considered prior to notifying the relevant person:

- What member of the practice team is already in contact with the relevant person
- What (if any) discussions have taken place?
- What is the relevant persons current understanding of the incident to date?
- Where will the conversation have taken place?
- Who will be present for the conversation
- What support is available to the relevant person pre, during and post conversation?

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- Who is the practice point of contact post discussion?

As soon as an incident has occurred or been identified, Cloister Road Surgery will ensure that the notification includes:

- An accurate account of the incident
- An explanation of the actions to be taken by the practice as part of the procedure

### **4.3 Summary of CQC**

CQC Inspections will report on “Duty of Candour” under the Key Question of Safety –

- Are people who use services told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result?
- Does the culture encourage candour, openness and honesty?

If the care provided does not reflect the required characteristics of “Good” (as defined in the CQC Provider Handbook), then inspections are recommended to assess whether the service “Requires Improvement” or “Inadequate”, and whether there has been a breach of the regulation.

As this is an issue that affects patient safety, any information received from a member of the public or Practice staff relating to Duty of Candour will be investigated in line with the CQC’s Safeguarding and Whistleblowing protocols where relevant.

### **4.4 Arranging a meeting**

When a notifiable safety incident has occurred, the relevant person must be informed as soon as reasonably practicable after the incident has been identified, up to a maximum of 10 working days (as per the NHS Standard Contract).

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

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

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Regulation 20 defines what constitutes a notifiable safety incident. It includes incidents that could result in, or appear to have resulted in, the death of the person using the service or severe harm, moderate harm, or prolonged psychological harm.

Where the degree of harm is not yet clear, the relevant person must be informed of the notifiable safety incident in line with the requirements of the regulation.

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 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.

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 Practice. 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 Practice should consider whether interpreters,



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advocates, communication aids etc. should be used, while being conscious of any potential breaches of confidentiality in doing so.

The Practice must also explain to the relevant person what further enquiries they will make.

The Practice must ensure that a meaningful apology is given, in person, by one or more appropriate representatives of the Practice to relevant persons. 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:

(<http://www.nhs.uk/claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf>)

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 – therefore the partners and or the practice manager in their absence should be the nominated individuals. The Being Open Framework referenced below provides guidance on this.

The Practice must 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, and other relevant support groups, to help them deal with the outcome of the incident

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- 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
- The Being Open Framework referenced below provides guidance on how to support patients, their families and carers when a patient safety incident has occurred

The Practice must ensure that written notification is given to the relevant person following the notification that was given in person, even though enquiries may not yet be complete.

The written notification must contain all the information that was provided in person including an apology, as well as the results of any enquiries that have been made since the notification 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, should they wish to receive them.

The Practice must make every reasonable attempt to contact the relevant person through all available communication means. All attempts to contact the relevant person must be documented.

If the relevant person does not wish to communicate with the Practice, their wishes must be respected and a record of this must be kept.

If the relevant person has died and there is nobody who can lawfully act on their behalf, a record of this should be kept.

#### **4.5 Review process**

Whilst the regulation does not specify the review process it is considered best practice if the review involves clinical professional with the relevant subject matter expertise and other individuals as deemed appropriate.

The written report of the review is to include the following:<sup>2</sup>

- A description of the manner in which the review was carried out
- A statement of any actions to be taken by the organisation for the purpose of improving the quality of service it provides and sharing learning with other persons or organisations in order to support continuous improvement in the quality of health, care or social work services

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- A list of actions taken for the purpose of the procedure in respect of the incident and the date each action took place

By including this information in the report, Cloister Road Surgery is able to demonstrate that they have taken into consideration the views of the relevant person and, a review has been undertaken.

It is recommended that written reports are written in such a manner so that the need for redaction is minimalised.

Cloister Road Surgery will send the relevant person the following:

- A copy of the written report
- Details of supporting information about actions taken for quality improvement purposes
- Details of support services available to the relevant person

#### **4.6 Record keeping**

Cloister Road Surgery will retain full records of each incident in relation to the duty of candour.

Annual reports

In accordance with the Regulation, Cloister Road Surgery will prepare an annual report which is aligned with the end of the financial year. The report must include:<sup>2</sup>

- Information about the number and nature of incidents to which the duty of candour procedures has been applied
- An assessment of the extent to which the responsible person carried out the duty of candour
- Information about the responsible person's policies and procedures in relation to the duty of candour (including information about procedures for identifying and reporting incidents)
- Information about any changes to the responsible person's policies and procedures as a result of incidents to which the duty of candour has applied
- Any supplementary information which is deemed appropriate by the responsible person

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Reports must not include the name of any individual or any personal identifiable information. Examples of report templates can be accessed [here](#).

## **5 Summary**

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Openness and transparency ought to be at the centre of the relationship between Cloister Road Surgery and our patients, their families and/or carers; it is pivotal to the provision of safe and effective patient-centric care. By adhering to the guidance contained within this policy, patient care will be delivered in a highly effective manner at all times.