Heathgate Medical Practice
Policies and protocols
Statutory duty of candour

Background

The Francis Inquiry report into events at Mid Staffordshire NHS Trust called for the establishment of a statutory duty of candour on both providers and individuals working in the NHS.

The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015 extend the requirement of the duty of candour to all providers from 1 April 2015.

This requires staff to disclose information to their employer where they believe poor care has, or could result in serious harm, injury or death of a patient. The duty may lead to criminal proceedings for staff trying to prevent someone exercising this duty.

The duty of candour defines openness, transparency and candour and supports the statement in the NHS Constitution that confirms that when mistakes happen, they are acknowledged, an apology is made, an explanation is provided, matters are investigated and that things are put right quickly and effectively.

The Practice has its own series of values, created and supported by staff. These also demonstrate our commitment to our patients to ensuring that we meet the obligations of the duty of candour.

Our values are:

- To be effective
- To be caring
- To be flexible
- To be professional
- To have dignity

Practice statement

The Practice fully supports the principles underlying the NHS duty of candour with anyone working in the Practice being open, honest and transparent in everything they do in order to provide the safest and appropriate care for our patients.

The professional duties on doctors to be open and honest with patients about their care and the sanction for failure underpin these standards.

The Partners intention is that there is a culture of openness and truthfulness when providing healthcare at Heathgate Medical Practice. If patients or employees have suffered harm as a result of our services, the

Practice will investigate, assess and if necessary apologise for the situation, explain what has happened and instigate changes to prevent it happening again.

Governance is considered in all we do; not only in the delivery of high quality healthcare for our patients but also ourselves internally. The Practice has a number of clinical and administrative policies, protocols and procedures to ensure we deliver high quality healthcare and prevent harm to our patients.

We commit to carrying out an investigation into patient complaints or incidents affecting our patient's well-being and safety and provide support for anyone involved in such incidents; to help cope with both the physical and emotional impact of such.

Definitions

Openness (as per the Francis report)
Enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

Transparency (as per the Francis report)
Allowing information about the truth about performance and outcomes to be shared with staff, patients, the commissioners of services, the public and regulators.

Candour (as per the Francis report)
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.

A sincere apology

The Francis Report indicates 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.

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.

The duty of candour acknowledges that an apology does not constitute an admission of liability.

Patients and relatives will request detailed explanations of what led to an incident occurring 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.

Levels of harm

No harm	Any incident that had the potential to cause harm but was prevented.
Low harm	An incident that required extra observation or minor treatment.
Moderate harm	An incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm.
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 someone receiving care.

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. 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

NHS Fundamental Standards of Care and CQC

The Practice is aware and supports the guidance outlined in the CQC guidance on this matter.

There are two key questions within the CQC inspection key lines of enquiry (KLOE) that are relevant to the duty of candour. These are:

Key Question	KLOE	Prompt
Is it Safe?	**S2**	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?
Is it Well Led?	**W3**	Does the culture encourage candour, openness and honesty?

Our internal assessment of both these KLOE is that we meet these expectations.

Summary

In summary the Partners fully endorse the NHS duty of candour that has been established under the Health and Social Care Act and commits to delivering the appropriate care, at the appropriate time, in the appropriate setting in an open and transparent way.

This statement will be shared with team members, reviewed and updated as necessary on an annual basis.

Reviewed by Garry Whiting 24th June 2023
For review no later than 24th June 2025