Duty Of Candour

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Contents

Introduction

Trent View Medical Practice (managed by Riverside Surgery) will fulfil its obligations to satisfy its duty of candour.
It aims 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."
The intention is that there is a culture of openness and honesty to improve the safety of patients, staff and visitors to Trent View Medical Practice (managed by Riverside Surgery) as well as raising the quality of healthcare systems. If patients or members of the Team 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.

Principles

Speaking up about any concern you have at work is important. It helps the practice to continue to improve its services for all patients and the working environment for staff.
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
- Offer an apology to the patient or, where appropriate, the patient's advocate, carer or family
- Offer an appropriate remedy or support to put matters right, where 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 practice 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 their representatives.
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.
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.

Policy Status

This policy is designed and implemented to 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.

Scope

This document applies to all members of the practice team whether employed, on secondment, contracted, locum or agency workers

Definitions

Duty Of Candour

To ensure that those providing care are open and transparent with the people using their services whether or not something has gone wrong.

- 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.

Openness

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

Transparency

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

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.

Patient Safety

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".

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 report.

Procedure

Recognising An Incident

The relevance of the duty of candour begins with an acknowledgement by a member of the Team that an incident has occurred as the result of a safety incident and that a patient has suffered a degree of harm. 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

A Sincere Apology

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

Action And Timescales

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 A sincere expression of apology must be provided verbally as part of this notification	Maximum 10 working days from incident being reported
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

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Job Title:	Business Support Administrator	Business Manager
Date of Issue:	December 2023	
Version Number:	V3	
Date of Review	December 2025	