Dr PJP Holden and Partners.

Imperial Road . Matlock . Derbyshire . DE4 3NL

Version Control Document.

Name of Policy: DUTY OF CANDOUR - OPENNESS			
Adopted Date	**Amendment Date**	**Reason for Amendment**	**Policy Renewal Date**
14th December 2015			December 2018

Policy Content:

1. Statutory Duty of Candour
2. Being Open.
3. Definition of Levels of Harm
4. Recognising an Incident
5. Issuing an Apology

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Duty of Candour

1. Statutory duty of candour

Extract from the NHS Constitution for England 2009: "…when mistakes happen to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively"

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";

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.

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, a 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.

2. Being Open

The Practice operates a culture of "being open" 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".

"Being open" and "Duty of Candour"

The Practice:

- Acknowledges, apologises and explain when things go wrong;
- Carry's out investigations into incidents affecting Patient Safety;
- Provides support for those involved in the incident (patients and staff) to cope with the physical and emotional impact;
- Reassures patients, families and carers that lessons learned will prevent any patient safety incidents happening in future;
- Reports incidents to NHS England for public health matters and North Derbyshire Clinical Commissioning Group for serious incidents as defined in the relevant policy.

3. Definition of "Levels of Harm"

Levels of harm are detailed within the North Derbyshire Clinical Commissioning Group Serious Incidents Policy and reporting by the Practice conforms to the requirements stated.

4. 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.

The Practice then follows the process and timeframes identified within the North Derbyshire Clinical Commissioning Group Serious Incidents Policy.

5. Issuing an 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.

To meet the requirements of **CQC Regulation 20**, the Practice is open and transparent with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity and will:

- 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.

Adopted: *Partners Meeting 14th December 2015*
Review Date: *December 2018*