POLICY DOCUMENT

Policy Title:	Duty of Candour
Policy Group:	Whole Hospital
Policy Owner:	CEO
Issue Date:	June 2024
Review Period:	32 months
Next Review Due	February 2027
Author:	Director of Patient Services
Cross References:	Management of serious incident
	Safeguarding
	Whistleblowing
	Compliments and Complaints
	Disciplinary
Evidence:	CQC: Guidance for providers Regulation 20: Duty of candour 2022
	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20
	Being Open – Saying Sorry When Things go Wrong' National Patient Safety Agency 2009
Computer File Ref.	O: Risk Management: Policies: Whole organisation
Policy Accepted by MT	21 June 2024
Sign-off by CEO	

Statement of purpose:

The key purpose of this policy is to ensure all staff apply Duty of Candour principles. Staff are required, through this Policy and the Duty of Candour regulation, to be open and honest whenever mistakes are made and harm is caused to a patient.

Policy Statement:

Holy Cross Hospital will be open and honest with patients when things go wrong with their care and treatment. To meet the requirements of the Duty of Candour regulation, we will at all times, and in all circumstances, be open and honest with our patients and their families about the standard and quality of care we have provided.

In particular, should we happen to cause harm to any patients:

- By failing to do something we should have, or

- By making an error in our care or treatment.

We will always acknowledge and explain this fully to the patient and family at the earliest possible opportunity and provide reasonable support to the patient and family after the incident.

Notifiable safety incidents

The statutory duty of candour includes specific requirements for certain situations known as ‘notifiable safety incidents’.

A notifiable safety incident must meet all 3 of the following criteria:

- It must have been unintended or unexpected.
- It must have occurred during the provision of an activity Holy Cross Hospital provide.
- In the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care.

If any of these three criteria are not met, it is not a notifiable safety incident (but remember that the overarching duty of candour, to be open and transparent, always applies).

Roles and Responsibilities.

1. Chief Executive.

It is the duty of the Chief Executive to lead by example and to hold himself/herself and others to account for complying with the legal and moral duties placed on providers of health care. Specifically, role holder will:

- Uphold the principles of the Duty of Candour regulation and commit to being open and honest
- Enforce the Hospital policy on Duty of Candour and promote a culture in which openness and honesty are valued
- Receive assurance reports from Director of Patient services demonstrating that, in all applicable instances, Duty of Candour conversations have taken place and that a written summary of the conversation has also been provided to those impacted by harm
- Ensure the Hospital has formal arrangements in place for the implementation of Duty of Candour principles

2. Freedom to Speak up Guardian.

Freedom to Speak Up Guardians are responsible for taking action to promote the following outcomes:

- Ensuring that concerns are dealt with appropriately.
- Safeguarding the interests of the individual, ensuring there are no repercussions for them either immediately or in the longer term and that they have access to personal support as appropriate.
- Helping to develop a culture where speaking up is recognised and valued.
- Maintaining a position of independence and impartiality.
- Preparing and providing regular reports of issues raised by staff, identifying key concerns and potential actions to be considered.
- Identifying common themes and ensuring learning is shared.
- Contributing and participating in staff training.

3. **Director of Patient Services.**
   Ensure that the professional standards of all reporting clinical staff are maintained, including the professional duty of candour as it applies to registered clinical professionals.
- Ensure that an explicit procedure for the management of Duty of Candour disclosures and related actions is in place, which includes processes for the monitoring and reporting of compliance.
- Ensure that copies of investigation findings arising from harm incidents are shared with the impacted patient and, where appropriate, with their families.
- Ensure that appropriate Duty of Candour communication has occurred with the patient/ family at an early stage, with a written summary of the conversation provided within 2 working days.

4. **Clinical managers and leaders.**
- Promote and proactively encourage a team and organisational culture in which openness and honesty are valued.
- Hold people to account in instances when they fail in their duty to identify and report patient harm.
- Initial communication to impacted patient or family and provide basic information and guidance on the next steps.

5. **All Staff**
- Be aware of and apply, the principles of the Duty of Candour.
- Uphold a low threshold for harm or distress to patients.
- Be vigilant in the identification of incidents causing patient harm.
- Report incidents at the earliest opportunity to their manager.

Procedure for the initiation and completion of Duty of Candour process.

1. MDT review.

Members of the multidisciplinary team should meet as soon as reasonably practical after the identification of the event to:

- Define if a notifiable safety incident has occurred.
- Establish the basic facts and timeline, clinical and other.
- Make an initial assessment of the level of harm caused.
- Identify who will be responsible for the communication and for ensuring that a written summary is provided within 2 working days of disclosure.
- Consider the appropriateness of engaging patient support at this early stage.
- Ensure there is a consistent approach in discussions with the patient and/ or their families.
- Identify any support needs for the healthcare staff involved.

2. Timing the initial discussion.

The initial discussion with the patient/ families should occur as soon as possible after recognition of the incident.

3. Selecting the individual to communicate with patient/ family.

This should be the most senior person responsible for the patient's care and/ or someone with experience and expertise in the type of incident that has occurred.

4. Incident involving healthcare staff who made mistakes.

In cases where the healthcare professional wishes to attend in order to offer personal apology, they should be accompanied and supported by a senior colleague(s).

Where there is a breach of hospital discipline, misconduct or gross misconduct, the human resource department will be involved to trigger the discipline procedure.

If the patient express a preference for the exclusion of an involved healthcare professional from the discussion, this should be honoured and the option of a written personal apology considered as an alternative.

5. Initial disclosure to the patient/ family.

The initial disclosure will be the first step in an ongoing dialogue with the patient/ family. Points raised in the initial disclosure should be expanded on in subsequent discussions.

The patient/ family should be advised of the identity and role of any staff attending the disclosure discussion and, if possible, this should be done ahead of the meeting to allow an opportunity to state their preferences about who should be present.

6. Documentation.

Communication of patient harm/safety incidents and Duty of Candour disclosure must be recorded in the patient's medical notes (section: Contacts).

A written summary of the disclosure discussion must be provided to the patient unless they have explicitly stated that they do not wish to have this.

Keep clear records of cases where Holy Cross Hospital has responded to notifiable safety incidents. It may be that the incident also meets the notification thresholds and if so should be reported to the CQC via their notification system.

7. Follow up meeting and completing the process.

Follow-up discussions with the patient/ family are an important step in the Duty of Candour process, during and following completion of investigation, which will be recorded in the patient's medical notes (section: Contacts).

It is expected that in all cases there will be a complete disclosure of the findings of the investigation and root cause analysis.

8. Supporting staff

When a patient harm/ safety incident has occurred, the healthcare professionals involved may also require emotional support and advice. Staff directly involved in the incident and those who have conducted Duty of Candour disclosures should be given access to assistance, support and any information they need to fulfil this role.

Staff training

New staff will receive induction training, which includes duty of candour policy. Existing staff will receive refresher training every 3 years appropriate to their level of responsibility.

Senior managers/directors will receive training in Root Cause Analysis to assist in the investigation process. They will also receive training/ clinical supervision in managing difficult conversations and the requirements of the Duty of Candour to support them in handling sensitive conversations with patients and their relatives.

GLOSSARY OF TERMS

Duty of Candour

Refers to the organisational and professional duty to inform a patient and, where appropriate, their family in circumstances in which moderate or severe harm or death has been caused as a direct or indirect result of the care or treatment provided or not provided. It is both a contractual duty and a legal requirement to ensure that Duty of Candour discussions are had with patients impacted by moderate or severe harm and/ or with their families, for example with the patient's consent or where the harm has led to the unexpected death of the patient.

Being open

Being open is a specific process of actions and behaviours following any incident causing harm to a patient. Organisations are said to be 'open' when the prevailing culture visibly encourages key behaviours. These include honesty, openness, appropriate sharing of information and a willingness to learn from experience to change individual/ group practices and/ or how an organisation functions.

Ten principles of being open

Being open is s process rather than a one off event. The following ten principles underpin this process:

- Principle of acknowledgement.
- Principle of truthfulness, timeliness and clarity of communication.
- Principle of apology.
- Principle of recognising patient and carer expectations.
- Principle of professional support.
- Principle of risk management and system improvement.
- Principle of multidisciplinary responsibility.
- Principle of clinical governance.
- Principle of confidentiality.
- Principle of continuity of care.

Appendix 1 –Equality impact Assessment (EIA) Tool

To be considered and where judged appropriate, completed and attached to any policy

document when submitted to the appropriate committee for consideration and approval.

Policy Title	Duty of Candour	Name	Gina Guo

	·- **Yes/No** **Comments**		
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	Race	No	
	Gender reassignment	No	
	Marriage & civil partnership	No	
	Pregnancy & maternity	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Sex	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation	No	
	Age	No	
	Disability- both mental and physical impairments	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	Is the impact of the policy/guidance likely to be negative?	No	
4.	If so can the impact be avoided?	**N/A**	
5.	What alternatives are there to achieving the policy/guidance without the impact?	**N/A**	
6.	Can we reduce the impact by taking different action?	**N/A**	
7.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	**N/A**	

Review

This policy has been reviewed for overt or implied discrimination within the scope of the Hospital's policies on equality and diversity and none was found.

The policy will be reviewed every 32 months to ensure that the system described continues to provide an effective framework for the duty of candour.