The Reddish Family Practices

Dr M Saksena Joye, Dr C Roberts, Dr S Marechal, Dr H Pattison

306 Gorton Road, Reddish, Stockport SK5 6RN

Tel: 0161 983 9797

www.thereddishfamilypractice.nhs.uk Email: gmicb-STO.P88005-admin@nhs.net

Duty of Candour Policy

Version:	Review date:	Edited by:	Approved by:	Comments:
V1.2024	02/07/2024	Jenny Webster		

Table of contents

1 Introduction

1.1 Policy statement

At The Reddish Family Practice, an open and blame-free culture is fostered. This approach can only exist when all service users, staff and any visitors believe that they are and will be fully supported should they raise any concern or complaint.

The purpose of this policy is to set out the rationale for having an open and blame-free culture and the underpinning principles that establish and promote such a culture within the organisation to promote our duty of candour.

This organisation promotes an ethos to not fear raising a concern because any genuinely made mistake will not be held against any person. Furthermore, all service users, staff and any visitors to the organisation will have the assurance that any incident will be thoroughly investigated and reported upon. This is due to our desire to promote a learning culture to both support the improvement of safety and to raise the quality of healthcare provision.

CQC GP Mythbuster 32: Duty of Candour and General Practice (Regulation 20) explains that this organisation must promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning.

- Regulation 20 sets out some specific requirements that this organisation must follow when things go wrong with care and treatment. This includes informing people about the incident, providing reasonable support and truthful information and providing an apology when things go wrong.

- Regulation 18 details notification of other incidents. Further details can be found within the link.

A culture of 'being open' is fundamental to the organisation's relationships with (and between) patients, the public, organisation staff and other healthcare organisations.

1.2 Status

The organisation 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 has been given to the impact this policy might have regarding 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. Furthermore, this document applies to all employees of the organisation and other individuals performing functions in relation to the practice such as agency workers, locums and contractors.

2 When a concern is found

2.1 Adopting an open and blame free culture

The organisation encourages a culture where all incidents and 'near misses' are reported and which allows for such events to be reviewed and any learning opportunities taken on board. In this way, the organisation seeks to continuously improve and avoid repeated mistakes.

To promote a working environment where talent can grow, the organisation management understands that employees must be allowed to learn from their mistakes, examine and reflect upon their errors and be encouraged to establish new ways of working that will support and promote best practice thereby reducing the likelihood of further occurrences.

Raising concerns can sometimes feel like 'complaining' or going behind others' backs and this can sometimes prevent people from speaking up, but employees should not be put off. The organisation is committed to an open and honest culture and will investigate what an employee says and will ensure they have access to the support they need.

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 they have made a disclosure. This means that their continued employment and opportunities for future promotion or training will not be prejudiced because they have raised a legitimate concern. The victimisation of a worker for raising a qualified disclosure will be a disciplinary offence.

This premise links directly with the organisation's commitment to the contractual duty of candour 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.

Further reading can be found in the practice **Freedom to speak up policy and procedure**.

2.2 Reporting incidents

All incidents must be reported immediately by each person involved/present at the time and reported through normal line-management channels to enable an initial review to be undertaken to bring about any immediate response that is necessary/appropriate.

Advice may be sought by management when there is any concern that there may be regulatory or other significant reporting issues involved and the process as detailed within the practice **Significant Event and Incident Policy** is to be followed.

All employees involved will be briefed. SEAs are reported via the Teamnet portal.

2.3 Learning and actions

All suggested improvements should then be agreed by management and an implementation plan developed and agreed.

The action plan will include:

- Responsibilities for actions
- Timeframes
- Monitoring and review arrangements
- Communications to support the implementation process

Individual employees' learning needs and actions will be discussed with them privately and recorded on their personnel file. Depending on the circumstances, this may be through informal or formal procedures with the purpose of enabling the employee to learn from any mistake and establish correct and/or improved working practices.

The relevant HR policy and/or Quality Assurance and Clinical Audit Policy may be used to support any ongoing actions.

3 When a concern is raised by a service user

3.1 Duty of candour

While being open is generally to promote a workplace culture, the same is also needed when a patient, family member or friend raises a concern. All incidents require a full investigation but, when it comes to service users, the term 'duty of candour' is used when any concern is raised or found.

Duty of candour is when there is a general duty to be open and transparent with people receiving care from this organisation. Regulation 20 explains that both the statutory duty of candour and the professional duty of candour have similar aims, to make sure that those providing care are open and transparent with the people using their services whether or not something has gone wrong.

The organisation will use the following definitions in relation to the duty of 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

3.2 Degrees of harm

The organisation will use the following CQC definitions when defining degrees of harm:

Moderate harm	Harm that requires a moderate increase in treatment and significant but not permanent harm
Severe harm	A permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition
Moderate increase in treatment	An unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment or transfer to another treatment area (such as intensive care)
Prolonged pain	Pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days
Prolonged psychological harm	Psychological harm that a service user has experienced, or is likely to experience, for a continuous period of at least 28 days

3.3 Notifiable safety incidents

Notifiable safety incident is a specific term defined in the duty of candour regulation. It should not be confused with other types of safety incidents or notifications. A notifiable safety incident must meet all three of the following criteria:

1. It must have been unintended or unexpected
2. It must have occurred during the provision of regulated activity
3. In the reasonable opinion of a healthcare professional, it already has, or might, result in death or severe or moderate harm to the person receiving care

If any of these 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).

A flow diagram at Annex A illustrates how to identify a notifiable safety incident.

3.4 Responding to a notifiable safety incident

The diagram at Annex B illustrates the process to be followed when a notifiable safety incident has been identified. CQC guidance states that the procedure must be

started as soon as reasonably practicable. It is essential that a written record of all communication with the service user is retained.

A letter template is available at Annex C. This template is saved on the shared drive under Duty of Candour Policy.

To further support, the CQC has provided an example of a notifiable safety incident within primary care.

3.5 A 'sincere apology'

NHS Resolution states that saying sorry is always the right thing to do, is not an admission of liability, acknowledges that something could have gone better and is the first step to learning from what happened to prevent it recurring.

Saying sorry meaningfully when things go wrong is vital for everyone involved in an incident including the patient, their family, carers and the staff who care for them. Detailed information is available in the NHS Resolution Saying sorry guidance document.

4 Reporting and further reading

4.1 Reporting an incident or concern

Depending on the degree of harm, the organisation must consider reporting the incident to the following:

- Integrated Care Board
- Care Quality Commission
- Learning from Patient Safety Events Service

4.2 Further reading

The following additional guidance can support this policy:

- Department of Health document titled Learning not blaming dated July 2015
- NHS Resolution Duty of candour animation dated March 2022
- GMC and NMC guidance titled Openness and honesty when things go wrong: The professional duty of candour dated June 2015
- The MDU guidance titled Duty of candour at a glance dated January 2024 and Primary care webinar dated October 2023
- Medical Protection Society An introduction to duty of candour dated July 2015

Annex A – How to identify a notifiable incident

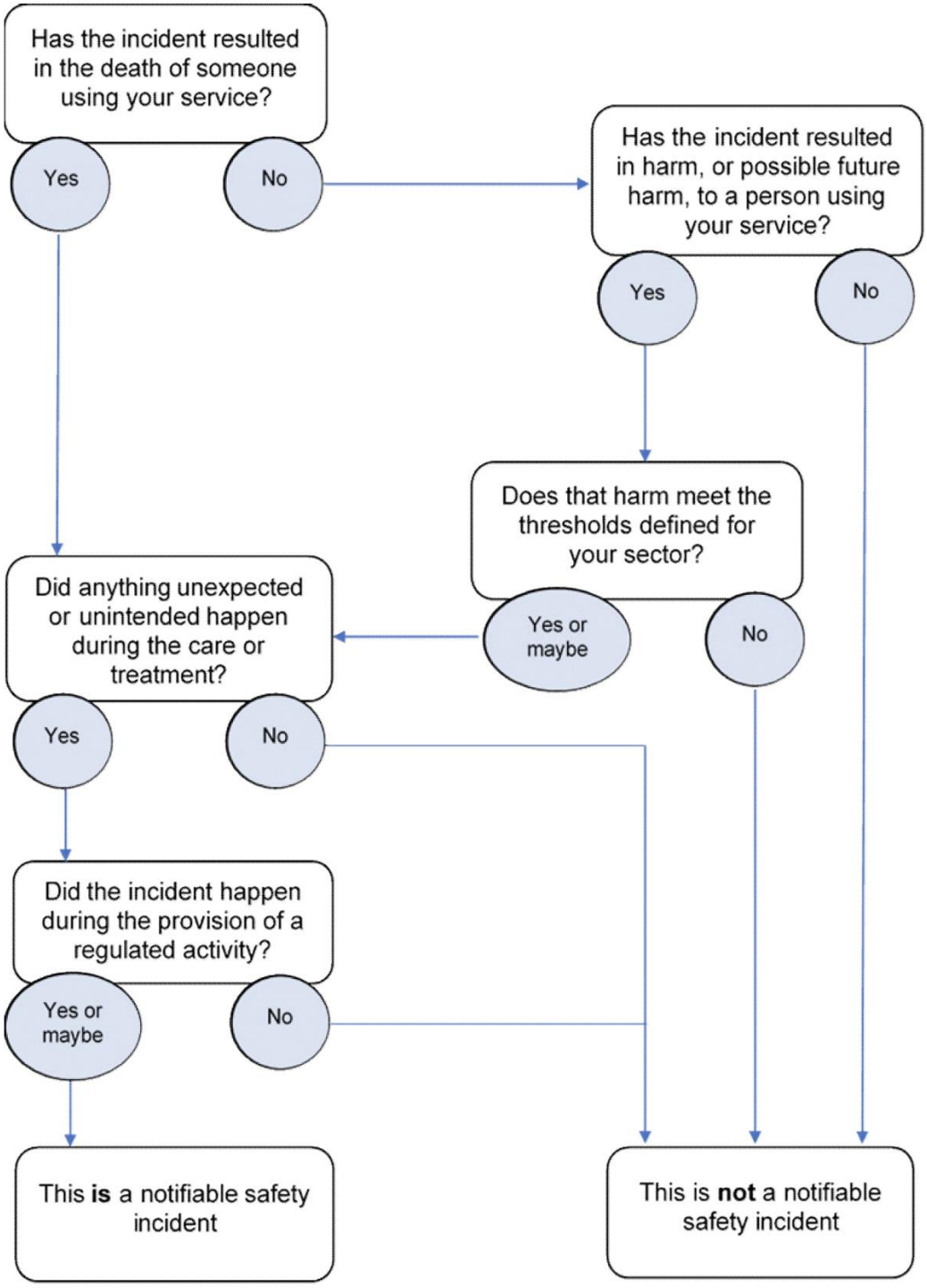

Image source: CQC

Annex B – Notifiable incident reporting process

Further reading can be sought from CQC guidance titled What you must do when you discover a notifiable safety incident (duty of candour).