NHS Litigation Authority Guidance on Candour

Introduction

From November 2014, NHS provider bodies registered with the Care Quality Commission (CQC) are required to comply with a new Statutory Duty of Candour (DOC). Independent sector health providers will also need to comply from 1 April 2015, subject to further legislation.

This involves giving patients accurate, truthful, prompt information when mistakes are made and treatment does not go to plan.

Whilst the Statutory Duty of Candour requirement is directly linked to providers’ CQC registration requirements, the principles sitting behind the new duty are wholly aligned to the wider drive around transparency and also entirely endorsed by the NHS Litigation Authority (NHS LA) in terms of health providers being open when errors are made and harm caused.

The following guidance seeks to demystify how to deliver on candour, whether within the set triggers in the CQC Regulations¹, or in a wider sense of achieving a wholly transparent culture in health provision.

What is candour?

- Recognising when an incident occurs that impacts on a patient in terms of harm.
- Notifying the patient² something has occurred.
- Apologising to the patient³.
- Supporting the patient further.
- Following up with the patient as your investigations evolve.
- Documenting the above discussions and steps.

When might it arise?

- Whilst the patient is an in-patient, i.e. at the "bedside".
- When a patient is back at home following discharge or via community based care.
- Following a patient's death.

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¹ CQC Guidance on the Duty of Candour
² Relevant person means the service user (patient) or a person lawfully acting on their behalf if the service user is deceased or lacks capacity
³ Saying Sorry Leaflet
What triggers the statutory duty of candour?

- The death of a patient when due to treatment received or not received (not just their underlying condition).
- Severe harm - in essence permanent serious injury as a result of care provided.
- Moderate harm - in essence non-permanent serious injury or prolonged psychological harm.

Providers may consider that they wish to embrace openness beyond the statutory duty of candour definitions to embed it within their staff organisational culture. There is a professional duty for healthcare practitioners to be candid with the patients.

The legislation does not include near misses.

What does candour look like?

- Open discussions between the patient and the healthcare provider when things go wrong.
- Acceptance by healthcare staff that open conversations will take place at an early stage.
- Reduction in overly defensive approaches to information sharing about incidents in relation to the patient in question.
- Engaging the patient with the outcome of investigations; and
- An apology in relation to the incident.

What is an apology?

- Clinical staff may worry that being open with patients may compromise the ability to deal with a claim if one is subsequently made by the patient. In reality candour is all about sharing accurate information with patients and should be encouraged. The facts are the facts and staff should be encouraged and supported to help patients understand what has happened to them.
- Where staff should be more cautious is where the facts are not yet know or where they are being asked to speculate beyond what is known. It can be more damaging to a relationship with the patient to speculate inaccurately than to investigate and find the facts and then provide the extra information.

**Saying Sorry**

Do's and Don'ts on candour:

- Do ensure your staff understand your organisation's incident reporting process and accurately report when things go wrong.
- Do understand what it means to be open with patients.
- Do ensure your staff understand their role within the organisation's statutory Duty of Candour requirements.
Do ensure staff are trained and supported on how to share information with patients when things go wrong both in principle and in practice. For example in relation to the notification discussion they need to have considered:

- Where should the conversation take place?
- Who should be part of and who should lead that conversation?
- What support should be available to the patient during the conversation and afterwards?
- Who will be the single point of contact following the discussion with the patient?
- Who will capture the discussion in writing and where will that documented account be held?
- If the patient is unable to hold the discussion who should be involved on their behalf? (e.g. because the incident was fatal or the patient lacks capacity or the patient wishes to nominate someone to do it for them).

Do ensure that when reporting any subsequent claims, copies of the documentation capturing candour in relation to the incident are sent to the NHS LA.

Do keep in mind that when something has gone wrong, this can be devastating to the staff involved and therefore do make sure support is available to them.

Do encourage feedback from patients about how your organisation is embracing candour and what improvements could be made to your approach.

Do not forget other avenues by which candour might arise i.e. not only incidents but also complaints and claims.

Do not assume that apologising to patients amounts to an admission in relation to a subsequent civil claim.

Do not miss the opportunity to share learning from such incidents and discussions through your organisation’s internal clinical governance routes.

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