POLICY TITLE:	Duty of Candour
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Policy Owner:	Mark Rice-Thomson, Senior Investigations & Inquest Manager
Ratified by:	Charles Young, Director of Quality
Responsible signatory:	Colin Quick, Chief Quality Officer
Outcome:	This policy: • Aims to ensure that near miss incidents, incidents and complaints are dealt with openly and honestly. • Strengthens and embeds a culture of openness and transparency across Priory. • Facilitates compliance with Regulation 20 requirements, and in the process improves the quality and consistency of communication with service users, their families and carers when notifiable safety incidents occur.
Cross Reference:	OP04 Incident Management, Reporting and Investigation OP03 Complaints OP05 Mental Capacity OP17 Advocacy OP36 Events to be Notified to the Regulatory Bodies in England OP36.2 Events to be Notified to the Regulatory Bodies in Wales OP36.3 Events to be Notified to the Regulatory in Northern Ireland H131 Patient Safety Incident Response policy

EQUALITY AND DIVERSITY STATEMENT

Priory is committed to the fair treatment of all in line with the Equality Act 2010. An equality impact assessment has been completed on this policy to ensure that it can be implemented consistently regardless of any protected characteristics (age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or beliefs, sex, sexual orientation), and all will be treated with dignity and respect.

In order to ensure that this policy is relevant and up to date, comments and suggestions for additions or amendments are sought from users of this document. To contribute towards the process of review, email LegalandComplianceHelpdesk@priorygroup.com

DUTY OF CANDOUR

CONTENTS

1 SCOPE

1.1 This policy applies to all sites and services across England, Northern Ireland and Wales. Where there are differences between nations, this will be clearly highlighted.

1.2 For services in Scotland, please refer to OP03.3 Duty of Candour (Scotland).

2 INTRODUCTION

2.1 The duty of candour is a general duty on registered providers and registered managers to be open and transparent with people receiving care. It applies to every health and social care provider that the Care Quality Commission (CQC) and Health Inspectorate Wales (HIW) regulate.

2.2 Following the 'Francis Enquiry' into the failings at the Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009, legislation has been put in place to ensure that Healthcare providers are open and honest when things go wrong to assist in avoiding the development of a culture of secrecy and defensiveness which led to the problems that the enquiry was investigating.

2.3 Service user safety incidents, particularly those causing significant harm, or having the potential to do so, can have devastating consequences for service users and their families. They are also distressing for the professionals involved. Being open about what happened and discussing incidents promptly and compassionately with those involved is the right thing to do and it often helps reduce the impact of these events.

2.4 'Those affected' include the person or service user (the individual) to whom the incident occurred, their family and close relations and colleagues involved in the care and support of the service user. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who have a direct and close relationship with the individual to whom the incident occurred.

2.5 The duty of candour applies to all incidents that do or have the potential to cause a moderate or severe level of physical, or prolonged psychological harm or death. These incidents will require statutory reporting, and as such only incidents that are formally investigated are recognised on Datix – refer to OP04 Incident Management, Reporting and Investigation. In addition, application

of this policy should be considered for near miss incidents that had the potential to result in significant harm

2.6 Priory's duty of candour applies to all Priory colleagues including senior management and up to and including Executive Level Team.

2.7 Openness and honesty can not only reassure the service user, their families or colleagues that the incident has been recognised and their concerns acknowledged, but also helps to prevent such events becoming formal complaints and litigation claims that can only add to the upset and distress to all involved.

2.8 Being open involves:
(a) Acknowledging, apologising and explaining when things go wrong
(b) Conducting a thorough review of the incident
(c) Learning from the incident and putting measures in place to stop any reoccurrence
(d) Providing support for those involved with the physical and emotional consequences of the incident.

3 ENGAGEMENT PRINCIPLES

3.1 It is our legal duty to comply with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and sections 4, 25(2), 28(1) and (2) of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 to create a culture of openness, transparency and candour.
(a) **Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
(b) **Transparency** – allowing the truth about performance and outcomes to be shared with colleagues, service users, the public and regulators.
(c) **Candour** – any service user 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, including breaches of confidentiality.

3.2 Nine principles inform the design of Priory's systems and processes for engaging and involving those affected by service user safety incidents as set out by the NHS England Patient Safety Incident Response Framework 2022:
1. Apologies are meaningful
2. Approach is individualised
3. Timing is sensitive
4. Those affected are treated with respect and compassion
5. Guidance and clarity are provided
6. Those affected are 'heard'
7. Approach is collaborative and open
8. Subjectivity is accepted
9. Strive for equity

3.3 Committing to being open and honest will create an environment where service users, their families and carers and colleagues can be assured that, in the event of an incident, they will:
(a) Receive the information that they need to understand what happened
(b) Receive the reassurance that actions will be taken to help resolve any negative effects of the incident
(c) Receive the reassurance that everything possible will be done to ensure that a similar type of incident does not recur
(d) Feel supported when things go wrong.

3.4 An open culture recognises that competent people make mistakes and we can learn from them, but has no tolerance for unprofessional, dangerous or negligent behaviour.

4 GUIDANCE FROM REGULATORY AND PROFESSIONAL BODIES

4.1 Guidance from the regulatory bodies includes a requirement for organisations to:

(a) Analyse incidents that could have caused harm
(b) Involve service users in making decisions about their care
(c) Have an effective complaints procedure
(d) Notify the regulatory bodies of a range of incidents resulting in harm or having the potential to cause harm to a service user
(e) To reflect published research evidence and guidance issued by appropriate professional and expert bodies as to good practice in relation to care, treatment and support of service users.

4.2 The GMC, NMC, BACP and other professional bodies have placed great emphasis on the duty of candour as outlined in the following linked documents:

NMC https://www.nmc.org.uk/standards/guidance/the-professional-duty-of-candour/read-the-professional-duty-of-candour/
GMC https://www.gmc-uk.org/ethical-guidance
BACP https://www.bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions/

5 THE IMPORTANCE OF COMPASSIONATE ENGAGEMENT AND INVOLVEMENT

5.1 The term engagement describes everything an organisation does to communicate with and involve people affected by a service user safety incident in a learning response. This may include the duty of candour notification, or discussion, and actively engaging service users, families and colleagues to seek their input to the response to develop a shared understanding of what happened.

5.2 There are compelling moral and logical arguments for engaging with those affected by a service user safety incident and involving them in a learning response. First, those affected by a service user safety incident may have a range of needs (including clinical needs) as a result and these must be met where possible. This is part of our duty of care. Meeting people's needs not only helps alleviate the harm experienced, but also helps avoid compounding that harm. While we cannot change the fact that an incident has happened, it is always within our gift to compassionately engage with those affected, listen to, and answer their questions and try to meet their needs.

5.2.1 Second, engaging with those affected by a patient safety incident substantially improves our understanding of what happened, and potentially how to prevent a similar incident in future. Service users, their family members, and carers may be the only people with insight into what occurred at every stage of a person's journey. Not including those insights could mean an incomplete picture of what happened is created. Similarly, colleagues have important contributions to make about their experience of the incident and the working environment at the time and should be supported to share their account.

6 **EXPECTATIONS** (following a service user safety incident – non-life changing incident)

6.1 An apology should be made as soon as possible after an incident to the service user/their family/carer by the most appropriate person. Do not to delay giving a meaningful apology for any reason as doing so is likely to increase their anxiety, anger, or frustration. This is not an admission of liability, but a sincere expression of regret for what has occurred. The service user and their family/carer can expect to be given a step by step explanation of what happened, based on the facts known at the time and as soon as practicable after the known incident, but this should be within four days. (See flow chart at **Appendix 1**). **OP Letter: 46 Duty of Candour Letter General Template** can be used as a guide to structure any initial written communications.

6.1.1 The most appropriate person to communicate with the service user and their family/carer will usually be the most senior person at a site level responsible for the service user's treatment, care or support, or someone who has expertise in the type of incident that has occurred.

6.1.2 The person communicating with the service user/ their family/carer will:

a) Ideally be known to and trusted by the service user
b) Have good knowledge of the facts relevant to the incident either from direct involvement or having been fully appraised of the facts at that particular time.
c) Be senior enough to have sufficient experience in relation to the type of incident and be credible to service users
d) Have excellent interpersonal skills, including being able to communicate with service users in a way they can understand, especially if the service user communicates non-verbally
e) Be willing and able to offer a meaningful apology, reassurance and feedback to the service user and their family/carer
f) Be able to maintain a medium to long term relationship with the service user and their family/carer where possible to provide continued support and information
g) Be culturally aware and informed about the specific needs of the service user
h) Keep their manager abreast of developments as a means of ensuring there is sufficient organisational knowledge of this process.

6.2 Information should be given to the service user and their family/carer in a format that they can understand and retain. It should be given considerately, respecting the service user's privacy and dignity. In the event that an incident occurs to a service user with cognitive impairment/ lack of mental capacity, the service user's nominated representative or carer will be involved in the Duty of Candour discussion, as well as the service user.

6.2.1 If a service user refuses to give permission for colleagues to contact their family/next of kin then a decision should be made by the key colleagues involved in respect of whether the request should be overridden due to the seriousness of the incident. If the incident is a safeguarding concern, due consideration should be given as to whether contacting the next of kin may increase the risk to any individual involved, this should be discussed and agreed with the respective Local Safeguarding team first.

6.2.2 An apology and explanation should:

(a) Be meaningful and specific
(b) Take responsibility, not make excuses
(c) Acknowledge and validate concerns and distress
(d) Aim to reduce the trauma felt when things go wrong and offer reparation whenever possible
(e) Take into account the fact that it will be more effective when the person feels heard and understood
(f) Acknowledge the emotional and psychological consequences
(g) Outline what will be done differently in the future to prevent reoccurrences
(h) Always be documented in the service user records creating a culture of openness
(i) Ensure that the service user knows who to contact if they need further information and give details of advocacy or other support agencies if needed.

6.3 Written and face-to-face explanations and apologies will be given, unless the service user, their families or their representatives explicitly decline an offer of a meeting. Note that further offers of meetings should be made given that people can and do change their minds about such matters.

6.4 The fact that the incident happened and an apology has been made is to be recorded in the service user records and a report made in Datix, Priory's Incident Reporting system. However, a record of any meetings must be kept, but filed separately from the service user's records. Copies of any minutes taken should be made available to service users and their families on request. A debriefing will also take place, and support will be given to colleagues involved if required. The Colleague Supervision system can be utilised for this process.

6.5 Service users, their families/carer and colleagues can expect to be kept updated if further investigation reveals more information than has been initially provided. Managers should ensure the provision of timely and accurate information.

6.6 Senior managers on site should also give consideration to discussing those incidents that caused no harm (near misses) but had the potential to cause serious harm, with service users and their family/carer, but need to make a local decision as to whether such a discussion should take place depending on local circumstances and what is in the best interests of the service user.

6.7 Where an incident involves a child with 'Gillick' competency, the child will be involved as appropriate in the discussions. The opportunity for the parents to also be involved will be provided, unless the child expresses a wish for them not to be involved. Where a child does not have 'Gillick' competency, consideration needs to be given to whether the meeting is with the parents (or the person with parental responsibility) alone, or for the child to also be present. In these instances the views of the parents should be sought.

6.8 The only circumstances in which it would be appropriate to withhold information from a service user with mental health issues or from their family is when advised to do so by the responsible clinician (usually the consultant psychiatrist), with oversight by the multidisciplinary team and relevant Medical Director, in those circumstances where it would cause adverse harm to the service user or others.

6.9 In the case of an adult service user, it is inappropriate to discuss information about an incident with a carer or relative without the express permission of the service user. Where a service user has learning difficulties, which may include difficulty in expressing their opinion verbally or where capacity concerns are noted, an advocate, agreed in consultation with the service user, should be appointed, this may be a relative or carer. The advocate should be focussed on making sure that the opinions of the service user are considered during the discussions. (See also OP05 Mental Capacity and OP17 Advocacy).

6.10 Where the service user uses a language other than English or a non-verbal language, an interpreter or translator will be used so that the opinions and wishes of the service can be expressed.

6.11 If service users or their families, advocates or carers wish to have copies of Priory policies or procedures, the information should be provided, and they should also be given support to understand the contents if they require it. Copies of policies will be printed from the Intranet to ensure that they are the current version, but if previous versions are required because of the date of the incident, assistance should be sought from the Legal & Compliance Helpdesk - LegalandComplianceHelpdesk@priorygroup.com. Copies of local procedures that were current at the time of the incident may also be provided on request.

7 COMMUNICATIONS WITH A SERVICE USER'S FAMILY/CARER (following a service user incident resulting in severe harm or death)

7.1 Priory promote systematic, compassionate, and proportionate responses to service user safety incidents, anchored in the principles of openness, fair accountability, learning and continuous improvement - and with the aim of learning how to reduce risk and associated harm.

7.2 If an incident has resulted in severe harm or death of a service user, it is appropriate to send condolences to the service user's family on behalf of the service and of Priory. This will be discussed between the divisional lead for quality and the Senior Investigations & Inquest Manager prior to sending, as to who is the most appropriate person for the letter to be addressed from. Should the family respond and seek involvement, the below should process should be followed and led by the Senior Investigations and Inquest Manager.

7.3 **Initial contact:**

Provide a clear introduction and offer a meaningful apology. Discuss the service user safety incident clearly and in language appropriate to the person. Your description should be based solely on what is known at the time and you must not make any causal or outcome predictions. Careful consideration will need to be given regarding the emotional state of the family when deciding when would be the most appropriate time to discuss what happened.

7.3.1 Explain what happens next – Describe any immediate actions that have already been taken in response to the patient safety incident. If a patient safety learning review is planned, you should set out how this will happen. An individual should be helped to make an informed decision about whether to be involved in the learning review by being given appropriate information about how the learning review will progress, and how they could be involved and supported throughout the process. Sharing **H Form: 159A** Patient Safety Information Booklet For Families and Carers may be helpful.

7.3.2 Address questions - You should make time to answer any questions or concerns. If you cannot answer certain questions, be honest about this and say you will come back to them with an answer once you've gathered more information, or direct people to a source of information that could give them an answer.

7.3.3 Identify key point of contact - Ensure those affected know who their point of contact is within Priory.

7.3.4 Explore support needs - Everyone will respond differently to incidents, and some people will be more aware of their support needs than others. Not everyone will need support and needs may change over time. You need to determine if someone needs support and if they do to respond appropriately.

7.4 **Continued contact:**

Schedule or discuss next contact (if required) - At the end of the initial contact you need to agree when the next contact will be, how contact will be made and who will make it. Any promised contact must be delivered.

7.4.1 Those seeking involvement should be:

1. Provided with a named main contact and informed who will conduct any learning response.
2. Allowed to bring a friend, family member or advocate with them to any meeting that is part of the learning response process they are involved in.
3. Given the opportunity to input to the terms of reference for the learning response, including being given the opportunity to request the addition of any questions especially important to them (note: this does not mean that their requests must be met, but they must have any decision not to meet their request explained to them).
4. Provided the family affected are willing and able to be involved in the decision about the timeframe, this should be set in consultation with them as part of agreeing the terms of reference.
5. Families should be given the opportunity to review the learning response report with a member of the learning response team while it remains in draft with a realistic possibility that their suggestions may lead to amendments (note: this does not mean that their suggestions must be incorporated but any decision not to incorporate their suggestions must be explained to them).

7.5 **Closing contact:**

Receipt of the final report will mark the end of the learning review process for everyone involved. Ask those affected if and they want to see the final report, and if they do, what the easiest format is for them to receive it. Make it clear when they can expect to receive a copy of the final report so that it does not arrive as a surprise. Ask people if they would like to discuss the final report. Consider offering to discuss the report on a video call or face-to face so that you can give immediate answers to their questions/comments. Explain how Priory will use the report and reiterate meaningful apology.

7.6 **No responses:**

If attempts to contact family or staff are unsuccessful:

- check the contact details used are correct and current
- consider alternate routes of contact
- review the communication that has been attempted to ensure it was appropriate for any possible needs of the recipient

- check informed choices have been given about the involvement opportunities

7.6.1 If there is no response after and the above points have been considered, continue the learning response without the involvement of the people affected.

7.7 NB: Please note that if there is a request for a legal advocate to be present at any meeting, this needs to be discussed with the Central Legal team

7.8 Lessons learnt from the incident and from subsequent discussions with the service user and family will be shared with colleagues to ensure that they are fully aware of the service users and family views regarding what happened.

8 INVOLVING AND ENGAGING COLLEAGUES

8.1 Colleagues involved in service user safety incidents should be supported and included in any learning response. **H Form: 159** Patient Safety Incident Investigation Booklet for Colleagues should be shared where relevant and appropriate to do so.

9 SUPPORT SYSTEMS

9.1 Families and colleagues may need to be signposted to support at any point during engagement or involvement in a learning response. Sources of support for families may include bereavement and mental health services and for colleagues, Mental Health First Aiders, Second Victim Support and CareFirst, Priory's Employee Assistance Provider.

9.2 Families/carers must be offered the involvement of an independent advocate in the event of a learning review being commissioned into the unexpected death of a patient/service user. The purpose of the independent advocate is to assist the family/carer to raise questions, support them during any learning review discussions they are involved in and to offer their assistance when reviewing and understanding the learning review report.

10 RECORD KEEPING

10.1 Written records of discussions and meetings should be kept, but not as part of the service user's record.

10.2 Records should include:

(a) The time, date and place of any discussions/meetings, including the names and positions of all those present
(b) The method of contact
(c) A summary of the content of the discussion
(d) The plan for providing further information
(e) Offers of support made
(f) Questions raised and answers given
(g) Plans for follow-up meetings
(h) Action points
(i) Copies of any letters sent.

10.3 The Datix Incident Reporting System will make reference where necessary to the Duty of Candour, for example outlining the early conversations that take place and the fact that apologies have been offered. Thereafter the Incident Reporting System will be kept updated with any later contact with a patient and or their family/carer.

10.4 Colleagues should be mindful that records can be disclosed to HM Coroner and this is a further reason to ensure accuracy and objectivity.

10.5 The Duty of Candour will be monitored by both completion and exception i.e. in those instances where colleagues have not provided an acknowledgement, apology and explanation and this is brought to the attention of the Divisional Director of Quality. In such instances mitigating actions will be taken and a review of the circumstances undertaken with feedback given to the relevant site.

11 CONSIDERATIONS WHEN OTHER RESPONSES ARE ONGOING

11.1 Any of the below listed responses may take place concurrently with, or following, Priory level response to a patient safety incident.

11.2 Complaints - There is a statutory requirement to investigate and respond to complaints. This should never be put on hold without the complainant's permission. Where possible, and if the complainant agrees, the complaint investigation and patient safety incident investigation should be carried out as one investigation.

11.3 Investigations should be combined so that the patient/family get all the answers they are seeking together. Note, however, that the complaint may not limit itself to learning issues. When it is not possible to combine the two responses, how communication with those affected is best managed needs to be considered and discussed with those involved.

11.4 Coroners Inquests - Engagement leads should ensure those affected are aware if there is to be a coroner's inquest and give them information about what this will entail.

11.5 Litigation - The investigation and resulting report should not be influenced by fear of litigation or reputational risk and must be compatible with the Duty of Candour. A patient's/family's decision to make a claim or consider making a claim should not alter the way they are engaged with and supported.

11.6 Police investigations - Families and staff affected by the incident should be informed of any delays to a learning response starting due to an ongoing police investigation.

12 REFERENCES

12.1 **Legislation**

Health and Social Care Act 2012 (Regulated Activities) Regulations 2014
Health and Social Care (Quality and Engagement) (Wales) Act 2020

12.2 **Guidance**

Care Quality Commission, Regulations 20: Duty of Candour, December 2022
CQC (2022) Duty of Candour: Guidance for providers
NHS England and NHS Improvement (2019) The NHS Patient Safety Strategy
NHS England (July 2024) Engaging and Involving Patients, Families and Staff following a Patient Safety Incident

13 ASSOCIATED FORMS

13.1 **H Form: 159** Patient Safety Incident Investigation - Information Booklet for Colleagues
H Form: 159A Patient Safety Incident Investigation - Information Booklet for Patients Families and Carers
OP Letter: 46 Duty of Candour Letter Template

14 EQUALITY IMPACT ASSESSMENT

14.1

How is the policy likely to affect the promotion of equality and the elimination of discrimination in each of the groups?			
Protected Characteristic (Equality Act 2010)	**Impact** Positive/ Negative/ None	**Reason/ Evidence of Impact**	**Actions Taken** (if impact assessed as Negative)
Age	None		
Disability	None		
Gender reassignment	None		
Marriage or civil partnership	None		
Pregnancy or maternity	None		
Race	None		
Religion or beliefs	None		
Sex	None		
Sexual orientation	None		
Other, please state:			
EIA completed by:			
Name: **Role/Job Title:**	Mark Rice-Thomson, Senior Investigations & Inquest Manager		
Date completed:	20.05.2025		

15 APPENDICES

15.1 **Appendix 1** – Duty of Candour Actions Flow Chart

APPENDIX 1

Duty of Candour Actions Flow Chart

As soon as incident occurs

Provide immediate support and assistance to the service user and any colleagues affected by the incident.

Record on Incident Reporting System

Discuss next steps with Line Manager/Senior Clinician to define Duty of Candour roles

Within 4 working days of incident being reported

Notify service user and/or other that the incident has occurred and establish as required whether service user consents to share information with family/carer

Notification must…

- Be verbal
- Be conducted in person
- Be conducted by the department involved and include the Senior Clinician/Manager whenever possible

Provide all facts currently known about the incident

Include an appropriate apology

Be supplemented by a written notification

Be recorded in writing in the service user records

Within 60 days of the incident being reported

Investigating Officer conducts investigation if incident reaches PSIRF threshold.

Offer interim update to service user/family during the course of the investigation and provide appropriate support to service user and colleagues

Maintain full written records of any meeting or other contact with the relevant person in relation to the incident

Record any refusal by the service user/family of a meeting or other contact or information in relation to the incident

Within 10 working days of investigation being closed

Offer to provide the service user/next of kin with the findings of the investigation report i.e. via a meeting or by sending the report

Provide copy of investigation together with letter