Policy statement

Under the Fundamental Standards Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Section 81 of The Care Act (2014), put simply, Candour means the quality of being open and honest.

Candour can only work when it is part of a wider commitment to safety, listening and learning, with an organisational commitment to continual improvement. Care and treatment is not risk free and evidence heard at the Dalton review (2014), confirmed what was already known.

When things go wrong in health or care settings, families want to know three things:

- To be told honestly what has happened.
- What can be done to deal with any harm caused?
- To know what will be done to prevent a recurrence to someone else.

The Duty of Candour applies to all Health and Social Care providers registered with the Care Quality Commission.

The Duty applies to all cases of “significant harm”. This new composite classification covers the requirements of the reporting duty for NHS and Social Care Providers currently in place with the Care Quality Commission.

These are:

- National Reporting and Learning System (NHS)
- Statutory Notifications (Social Care)

In Social Care this is the “harm threshold”, which is breached when a statutory notification is required by CQC. Further guidance in this regard is to be issued shortly.

Compassion, Humanity and Candour

The obligations and challenges of Candour serve to remind us that for all its technological and forensic advances health and social care is still a deeply human activity. Systems and processes are necessary supports to good compassionate care, but they can never serve as a substitute.

Following on from this, is that making reality of Candour is a matter of hearts and minds more than a matter of systems and processes, however important they may be. A compliance focused approach will fail. Organisations need to start from the simple recognition that Candour is the right thing to do.

The commitment to Candour has to be about values, rooted in the genuine engagement of staff, building on their own professional duties and personal commitment to Service Users. It is right to be clear about thresholds and enforcement but nothing will be gained if we lose sight of the fundamental purpose of Candour, which is to do the right thing for all users of health and social care services.

"Notifiable safety incident" means any unintended or unexpected incident that occurred in respect of a Service User during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in:

- the death of the Service User, where the death relates directly to the incident rather than to the natural course of the Service User's illness or underlying condition.
- severe harm, moderate harm, or prolonged psychological harm to the Service User; "prolonged psychological harm" means psychological harm which a Service User has experienced or is likely to experience for a continuous period of at least 28 days.
- "relevant person" means the Service User or in the following circumstances, a person lawfully acting on their behalf.
- where a Service User is under the age of 16 and not competent to make a decision in relation to their care or treatment, or where the Service User is over the age of 16 and lack capacity (as determined by the Mental Capacity Act 2005) in relation to the matter.
- "severe harm" means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions including removal of the wrong limb or brain damage, which is related directly to the incident and not related to the natural course of the Service User's illness or underlying condition.

The guidance set out below should be followed, as soon as reasonably practicable, in order to fulfil our duty as a provider:

- Notify the relevant people that the incident has occurred, i.e. family, Next of Kin, Advocate etc.
- Provide support to the relevant person, where appropriate, including when informing them of the incident.
- Where possible, the information should be given in person.
- An account of the incident should be provided, which is factual and true at the date of the notification.
- Advise all parties of the relevant steps or actions that have been or, are to be taken.
- Include an apology.
- Record the incident and all steps and actions taken.
- The notification must be followed up in writing, confirming all of the above points.

If the relevant person declines to engage in the process, this should be recorded and any attempts to engage with them should be clearly documented.

In this regulation:
"Apology" means an expression of sorrow or regret in respect of a Notifiable safety incident.
"Notifiable" means to an external regulator, i.e. Care Quality Commission (CQC), Health and Safety Executive (HSE).

Separate guidance is to be issued with regard to this Regulation and this policy will be reviewed and amended upon the publication of any future guidance.

Training Statement

The Senior Management must be fully aware of this legal duty and it will be incorporated into the organisations induction process. A separate briefing must also be in place for all staff involved in governance within their job role.

All staff will be made aware of this policy and a lack of commitment or understanding will lead to disciplinary action being taken, with a clear action present of implementing a culture of openness and accountability.