Care is normally provided by multidisciplinary teams, and we don't expect every team member to take responsibility for speaking to patients. The multi-dsciplinary team should meet as soon as possible after the incident to:

- Get the facts straight
- Identify options for further support to the patient
- Nominate a member of the team who will communicate with the patient
- Arrange a meeting for the conversation to take place in a location which offers privacy

Saying Sorry

One of the barriers towards candour is the fear of litigation. NHS Resolution, the organisation that manages clinical negligence claims against the NHS, confirm that apologising is not an admission of liability. In their leaflet Saying Sorry, they make it clear that saying sorry is:

- always the right thing to do
- not an admission of liability
- acknowledging that something could have gone better
- the first step to learning from what happened and preventing it recurring

The way you say sorry is just as important as saying it. An apology should demonstrate sincere regret that something has gone wrong and this includes recognised complications referred to in the consent process.

Where possible you should say sorry in person and involve the right members of the healthcare team. It should be heartfelt, sincere, explain what you know so far and what you will do to find out more.

Don't say

✗ I'm sorry you feel like that
✗ We're sorry if you're offended
✗ I'm sorry you took it that way
✗ We're sorry but

Do say

✓ I'm sorry X happened
✓ We're truly sorry for the distress caused
✓ I'm sorry, we have learned that….

Where can I go for more information?

- STHFT Duty of Candour Policy
- CQC Duty of Candour: Guidance for Providers
- Professional Duty of Candour (GMC and NMC)

Alternatively speak to your Line Manager or contact the Risk/Governance Lead in your Directorate.

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Duty of Candour

INFORMATION FOR STAFF

Introduction

Every year we successfully care for thousands of patients, but unfortunately sometimes the outcome is not what we intended and our patients suffer harm. When this happens we owe it to our patients, their families and loved ones to be honest about what happened and to investigate to ensure that where there are lessons to be learnt, these are identified and action is taken to reduce the risk to others. Not only is this the right thing to do, there are some circumstances when organisations and healthcare professionals are required take this approach and this is known as Duty of Candour.

Since November 2014, the Duty of Candour became a legal requirement in some circumstances, in addition to the professional responsibility of healthcare professionals to be open and honest with their patients.

What is Duty of Candour?

According to the Oxford Dictionary, a Duty is a moral or legal obligation, or a responsibility and Candour is the quality of being open and honest.

The ***professional duty of candour*** means that healthcare professionals must:

- tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong and apologise
- offer an appropriate remedy or support to put matters right (if possible)
- explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long term effects of what has happened.

The ***statutory duty of candour*** for healthcare organisations is triggered when a safety incident has occurred that meets the threshold of a 'notifiable safety incident' - an incident that has resulted or has the potential to result in moderate harm, severe harm or death. The presence or absence of fault has no impact on whether or not something is defined as a notifiable safety incident.

In these cases, all healthcare organisations registered with the Care Quality Commission (CQC) have a legal obligation to ensure that patients (or, where appropriate, the patient's advocate, carer or family):

- are told of a 'notifiable safety incident' as soon as is practical.
- receive an apology, along with an explanation of what's known at the time, and what further enquiries will be made.
- are offered reasonable support - this could be practical (e.g. an interpreter or the support of an advocate) or emotional (e.g. counselling).
- receive the apology in writing along with a summary of the initial discussion including an update on any further enquiries within 10 days of the initial conversation.

The statutory duty applies to organisations, not individuals, however staff need to make sure that the organisational obligation is met.

How did it come about?

The statutory Duty of Candour was introduced in response to one of the key recommendations from the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Inquiry, 2013).

The Francis Inquiry concluded that there seems to be a near universal agreement that candour is an essential component in high quality healthcare, but that openness, transparency and candour are frequently not observed.

How is it decided whether an incident led to moderate, major or catastrophic harm?

At Sheffield Teaching Hospitals we have guidelines on grading incidents which can be found in the STHFT Incident Management Policy. Incidents are graded on the Datix Risk Management system by a senior member of staff in the organisation (this individual varies within each Directorate).

How does it affect me?

The first step in duty of candour is reporting an incident - If you witness or are involved in an incident, you should complete an incident report on the Datix system.

Where an incident has led to moderate, severe or catastrophic harm to the patient, if you are part of the team caring for the patient you may be involved in the duty of candour process outlined above.