NHS
Queen Victoria Hospital
NHS Foundation Trust

Duty of Candour: Patient Information Leaflet

We have a legal duty to be open and honest with patients (or 'service users'), their families or carers when something may have gone wrong and which appears to have caused or could lead to significant harm in the future. This is called the Duty of Candour. It applies to all health and social care organisations registered with the regulator, the Care Quality Commision (CQC) in England.

This leaflet explains what you can expect from the process and we hope it will help you to better understand what will happen, what it means and your role in the investigation.

What kind of incidents are covered by the duty of candour?

The regulations for registration with the CQC place an overarching responsibility on health and social care organisations to be open and transparent.

The regulations for NHS bodies define a 'notifiable safety incident' as 'an unintended or unexpected incident….that could result in, or appears to have resulted in the death of a service user…or severe or moderate harm or prolonged psychological harm to the serivce user.'

In other words, the organisation must tell you about any incident where the care or treatment may have gone wrong and appears to have caused significant harm, or has potential to result in significant harm in the future.

What can you expect when you are told about an incident?

We appreciate this may be a difficult time for you, and that there is never a good time to have the initial conversation about this incident. This is what you can expect from the Duty of Candour process:

- A member of staff will discuss the situation with you honestly and openly as soon as possible
- Once the investigation is up and running we will contact you, usually by letter, to let you know who your named contact is. Please let us know if you would rather have this information via post, email or a phone call.
- We value your contribution to the investigation at any time throughout the process
- We will try and answer any questions you may have. However, some of your questions may not be able to be answered until the investigation is complete.
- We will share the findings of the investigation with you when it is complete.

What does this mean for you?

To complete a thorough investigation, a great deal of information has to be gathered and analysed. We have a maximum of 60 working days to investigate what happened and produce a written report. Sometimes, an investigation may take longer, for example, if we need to seek external expert opinion, or if it is very complex. We will advise you of any delays as and when they arise.

As this is a formal report it is important for you to be aware that it can appear a little impersonal in how it is written. This is because the report needs to be structured and factual in order to see exactly what happened. However, please be assured that you, and the impact of what happened to you, is always our focus throughout the investigation process. Additionally, it is important for us to inform you that sometimes, even after investigation, we do not always find a clear cause for what happened.

Although the report is used mainly by us, the report may also be made available to our commissioners, Her Majesty's Coroner and other agencies if appropriate. For this reason, the report will not include your name or details. Additionally, completed records are not kept in your medical records.

Will it affect your on-going care?

Although you may feel anxious about discussing your experience with the people who have been treating you, especially if you need further treatment, we would like to assure you that any future care you receive will be delivered with respect, compassion and dignitiy. However, we recognise that you may wish to receive treatment from another team or provider and we will of course make arrangements for this, as required.

What about older incidents?

The duty of candour regulations came into force in November 2014 for NHS bodies. If the incident occurred before the regualtions came into force, the CQC may not be able to take formal regulatory action. However, they will take into account of how organisations follow the spirit of the duty currently. The regulations apply from the point that it is apparent that the incident is a 'notifiable safety incident' even it is only realised later (for example, through a complaint investigation) that it meets the definition of a 'notifiable safety incident'.

What you need to know

- The duty covers any incident that appears to have caused, or has potential to cause significant harm
- Organisations do not legally have to tell you about incidents that cause a 'low level of harm' (e.g., minor or short-term harm) or 'near misses' but it is good practice for them to be open and learn from all incidents
- There does not need to be certainty that an incident has caused significant harm – only that it appears that it has or may do do in the future
- Incidents will be covered if the 'reasonable opinion of a healthcare professional 'would be that it did or could have caused significant harm
- The emphasis should be on being open with you if there is any doubt

Is support available if I need it?

Yes. Details of support can be found below. In addition, the person leading the investigation will help to identify specific support relevant to your needs.

Healthwatch - Healthwatch - West Sussex is the local consumer champion in health care and works to share information, expertise and learning in order to improve health and social care services.
Telephone: **0300 012 0122**
E-mail: helpdesk@healthwatchwestsussex.co.uk
Website: www.healthwatchwestsussex.co.uk

The Advocacy People - Independent advocacy services to help resolve issues or concerns you have about your health or healthcare services.
Telephone: **0330 440 9000** or Text to 80800 starting with message PEOPLE
E-mail: info@theadvocacypeople.org.uk
Website: www.theadvocacypeople.org.uk

Action against Medical Accidents - An independent charity which can provide free and confidential advice and support through its helpline or put you in touch with one of its accredited solicitors specialising in medical negligence.
Telephone: **0845 123 2352** (Mon-Fri 10-15.30)
Website: www.avma.org.uk

Cruse Bereavement Care - Provides information and support to anyone affected by a death.
Telephone: **0300 311 9959** (West Sussex) **0808 808 1677** (National)
E-mail: westsussexarea@cruse.org.uk
Website: www.cruse.org.uk

Please ask if you would like this leaflet in larger print or an alternative format.

Issue 2 – Ref: no. 0585
Approved by the Patient Information Group
Print March 2021 – Review March 2024