

# Duty of Candour Policy and Procedure

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# Duty of Candour Policy and Procedure

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<b>Signed</b>	Simon Buxton - Director

## Introduction

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 describe statutory provisions regarding Duty of Candour (Regulation 20).

The regulation makes it a statutory requirement that providers act in an open and honest way to service users, should their care not go to plan, and harm was caused to the service user as a result.

Being open about what happened and discussing service user safety events promptly, fully, and compassionately with service users can:

- Help service users heal following an adverse event.
- Provide an environment where service users, carers and managers feel supported when things go wrong.
- Allow service users be involved in the investigation to ensure their opinions and ideas for improvements are included.

## Purpose

The purpose of this policy is to describe our approach to discharging the Duty of Candour, it will make reference to the below terminology:

### Duty of Candour

The statutory duty to be open and honest with service users, when something goes wrong which appears to have caused, or had the potential to have caused, harm.

### Service user Safety Event

An adverse event which caused, or had the potential to have caused, harm to a service user.

### Serious Incident

Serious incidents include acts or omissions in care that result in:

- Unexpected or avoidable death.
- Unexpected or avoidable injury resulting in serious harm, including those where the injury required treatment to prevent death or serious harm.

## **Duties**

The below outlines the relevant duties of management and Staffs with regards to the Duty of Candour.

### **The Director**

The Director will be assured that the processes in place regarding Duty of Candour work effectively and is committed to promoting a culture of openness within Banquo Limited. The Director will also review reports regarding incidents on a regular basis to ensure that the service within Banquo Limited does not falter, improvements made, and concerns mitigated.

### **The Registered Manager**

The registered manager has overall responsibility for integrated governance, including risk management and governance within Banquo Limited which includes the process, management, and response to the Duty of Candour process and legislation, as well as being responsible for service user safety. The Registered Manager can seek support from the local authority, stakeholders, and delegate appropriate responsibility to Staffs of Banquo Limited.

### **Staff**

All staffs must make themselves familiar with this policy and the process to discharge their professional Duty of Candour. Further to this, staffs have a responsibility for ensuring that all service user safety events are acknowledged and reported as soon as they are identified in line with Banquo Limited's Management of Incidents Policy and Procedure. This includes providing an immediate apology, rectifying immediate concerns and following an appropriate line of reporting via the incident reporting system. They must be aware that other staffs might require support during the investigation and provide the appropriate help and guidance for them which may in some cases come from external agencies.

## **Identifying The Need For Duty Of Candour**

As soon as a service user's safety event is identified where harm has occurred, the priority is to ensure appropriate care is provided and action taken to prevent further harm. Whenever practicable, appropriate discussion and service users consent should be gained prior to providing additional care.

### **Where No Harm Or Low Harm Has Occurred:**

Banquo Limited considers it best practice to inform service users and carers when something has gone wrong and apologise at the time of the event. No written apology will be provided unless requested by the service users.

### **Where Moderate, Severe, Or Catastrophic Harm Has Occurred:**

A verbal apology will be given as soon after the event as possible. A written letter of apology will be sent by the Registered Manager. A copy of the investigation report will be provided on completion of the investigation if those involved indicate that they would like to see a copy.

### **Who To Inform**

Wherever possible, Duty of Candour discussions must be held with the service users directly. This is not always possible, such as when the service user has died, or due to their circumstances or their age, or if the service user wishes someone else to represent them.

The Registered Manager must satisfy themselves that they are speaking with the service users. In all other instances, suitable consent must be gained prior to discussions commencing and should be requested in the initial contact.

### **Making Initial Contact**

Wherever possible, discussions should be held in person and, as such, an initial telephone call to briefly explain the need to meet and make arrangements is deemed as best practice. If there is uncertainty as to the most appropriate person to communicate with, or telephone contact details are not available, an initial letter should be sent asking the person to make contact so that Duty of Candour can be discharged.

### **Duty Of Candour Meetings**

The individual delivering the Duty of Candour message to the service users should be a senior member of the team, ideally responsible for the area in which the incident occurred. They should have a good grasp of the facts relevant to the incident and be aware of any interim findings so far in the investigation. Where possible, the senior manager should be supported by the investigating manager during this meeting to ensure the views of the service users are considered during the subsequent investigation.

### **The Meeting Must Include:**

- Introductions of all present and an explanation of why the meeting was arranged.

- An apology.
- A detailed and honest account of all the facts that Banquo Limited currently has about the incident, and what action has been taken so far.
- An explanation of the level of investigation that is being conducted, how this will occur and the anticipated timescales.
- A discussion to determine any questions or concerns that the service users specifically wish to be investigated.
- Agreement between parties of how often to be kept updated on the progress of the investigation.
- Gathering of facts from the service users as appropriate.
- Confirmation that a written summary of the meeting will be provided in a letter
- The content of the meeting must be documented in written notes and attached to the incident record.

### **Follow Up Meeting:**

- The facts must be communicated clearly, avoiding confusion, and must not either apportion blame or deny responsibility.
- Any areas where there is disagreement should be deferred to a subsequent meeting after the investigation has been completed.
- Where the incident investigation is still in progress, then the service users will be informed that more information will become available and new facts may emerge as the investigation progresses.
- The meeting should provide an overview of the incident reporting and investigation process, and the complaints procedure.
- Where there are legal restrictions on the disclosure of information, these restrictions need to be made clear to all meeting attendees. An explanation of the next steps needs to be given.
- The service users should again be signposted to sources of emotional support or help that is available to them.

### **Follow Up Letter**

Following completion of the initial Duty of Candour meeting, a summary of the discussion must be presented to the service users in a letter format. This shall be sent as soon as is practical after the meeting occurred, and a copy stored in the relevant incident record. The Duty of Candour letter template shall be used.

### **Subsequent Discussions And Sharing Findings**

Similar considerations to the initial meeting need to be taken for any preliminary follow- up and subsequent meetings or correspondence. Factual feedback needs to be given on progress- to-date and information provided on the investigation process. There should be no speculation or attribution of blame.

On conclusion of the investigation, the full findings of the investigation shall be shared with the service users, with a copy of the approved report provided to them if they wish to receive a copy. This will include the actions to be taken as a result of the investigation and the timeframes for completion.

If the service user or their relative wishes to receive assurance in relation to completion of the actions, this will be offered in the form of a follow up letter. If this is to be the last discussion, the service user/relative/representative and/or the service user's carers should be asked if they are satisfied with the investigation and a note made in the records.

Contact details will be provided to the service user/relatives/representatives and/or the service user's carers so that if further issues arise these can be linked back to the relevant case.

## **Support**

Banquo Limited recognises the importance of appropriate support to service users and their carers during difficult times. Banquo Limited representative is responsible for discussing support needs with the service users, and carers and consider whether it would be appropriate to offer further support, i.e. through their GP, registered charities and other relevant organisations. If this is indicated, the staff can liaise with the management team for appropriate signposting to the relevant service.

It is also acknowledged that staffs involved in an incident which requires Duty of Candour implementation then they may require additional support. This will be accessed initially through their line manager, and other options include occupational health or their union.

## **Documentation Of Duty Of Candour**

Banquo Limited requires all communication relating to an incident, complaint, enquiry or a claim to be documented, to establish a clear record of contact. Should a deviation be made from best practice, any rationale or reason for this must be documented.

Records of all meetings, telephone calls and letters sent must be kept, and attached to the relevant incident on the Banquo Limited incident reporting system.

A copy of the notes of any meetings with service users will be provided to all of the individuals present, for their own records.

The Duty of Candour record for each meeting will contain the following information:

- The time, place, date, and names of the attendees.
- Questions raised by the service user, family and/or carers or their representatives, and the answers given.

- Plans for follow-up as discussed.
- Copies of letters sent to service users, carers, and the local authorities.
- Copies of any statements taken.

## **Erroneous Identification**

It is possible that upon investigation of an incident initially thought to have caused harm, it is identified that this decision was made erroneously. In such circumstances the principles of truthful, timely and open communication continue to apply, with full and consistent explanations being provided to the carers involved, service user and/or carer and any relevant organisations. Similarly, the identification and dissemination of any learning points continues to be an important part of the Duty of Candour Policy and Procedure.

## **General Principles Of Openness And Honesty**

In order to ensure that Banquo Limited complies with the general principles of openness, honesty and transparency, Banquo Limited commits to the following:

- Publication of summaries of serious complaints via the organisation website and staff/carers intranet (subject to service user/family approval).
- Publication of discovery Interviews with service users via the organisation website and staff/carers intranet (subject to service user /family approval).
- Sharing of key issues and learning from serious incidents, service user safety issues and complaints with the local authority to maximise service improvements wherever possible.
- Publication of trends and themes across the organisation to enable carers/staffs to assist in safety improvements.

## **Related Policy And Procedures**

Adult Safeguarding Policy and Procedure

Confidentiality Policy and Procedure

Quality, Governance and Risk Policy and Procedure

Incident Management Policy and Procedure

Grievance Policy and Procedure

Freedom to Speak Up Policy and Procedure

Whistleblowing Policy and Procedure

## **Legislation And Guidance**

NHS England Serious Incident Framework (2015)

[Regulation 20: Duty of candour - Care Quality Commission \(cqc.org.uk\).](https://www.cqc.org.uk/regulation/20-duty-of-candour)

## **Appendix 1 The 10 Principles Of Being Open**

Being open involves apologising when something has gone wrong, being open about what has happened, how and why it may have happened, and keeping the service user and their family informed as part of any subsequent review.

### **1. Principle of Acknowledgement**

All service user safety events should be acknowledged and reported as soon as they are identified. In cases where the service user, their family and carers inform healthcare employees that something has happened, their concerns must be taken seriously and should be treated with compassion and understanding by all employees. Denial of a person's concerns or defensiveness will make future open and honest communication more difficult.

### **2. Principles of Truthfulness, Timeliness and Clarity of Communication**

Information about a service user safety incident must be given in a truthful and open manner by an appropriately nominated person. Communication should be timely, informing the service user, their family and carers what has happened as soon as is practicable, based solely on the facts known at that time. It will be explained that new information may emerge as the event investigation takes place. Service users, their families and carers and appointed advocates should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have.

### **3. Principle of an Apology**

Service users, their families and carers should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm that has resulted from a service user safety event or that the experience was poor. Both verbal and written apologies should be offered. Saying sorry is not an admission of liability and it is the right thing to do. Verbal apologies are essential because they allow face to face contact, where this is possible or requested. A written apology, which clearly states the organisation is sorry for the suffering and distress resulting from the service user safety event, should also be given.

#### **4. Principle of Recognising Service user and Carer Expectations**

Service users, their families and carers can reasonably expect to be fully informed of the issues surrounding a service user safety incident, and its consequences, in a face to face meeting with representatives from the organisation and/or in accordance with the local resolution process where a complaint is at issue. They should be treated sympathetically, with respect and consideration. Confidentiality must always be maintained. Service users, their families and carers should also be provided with support in a manner to meet their needs. This may involve an independent advocate or an interpreter. Information enabling to other relevant support groups will be given as soon as possible and as appropriate.

#### **5. Principle of Professional Support**

The Service provider has set out to create an environment in which all employees are encouraged to report service user safety events. Employees should feel supported throughout the service user safety event investigation process; they too may have been traumatised by the event. Where there is reason to believe an employee has committed a punitive or criminal act, the Service provider will take steps to preserve its position and advise the employee at an early stage to enable them to obtain separate legal advice and/or representation. Employees should be encouraged to seek support from relevant professional bodies. Where appropriate, a referral will also be made to the Independent Safeguarding Authority.

#### **6. Principle of Risk Management and Systems Improvement**

Within the Company the numbers of service user safety incidents are small and are all discussed at the Care management level. Investigations at any identified level will however focus on improving systems of care, which will be reviewed for their effectiveness. Being open is integrated into service user safety incident reporting and risk management policies and processes.

#### **7. Principles of Multi-Discipliner**

Being open applies to all employees who have key roles in service user care. This ensures that the being open process is consistent with the philosophy that service user safety incidents usually result from system failures and rarely from actions of an individual. To ensure multidisciplinary involvement in the “Being Open” process, it is important to identify clinical/care and managerial leaders who will support this across the health and care agencies that may be involved. Both senior managers and staff will be asked to participate in the service user safety incident investigation and clinical risk management as set out in the respective “company’s” policies and practice guidance.

## **8. Principles of Clinical Governance**

“Being open” involves the support of service user safety and quality improvement through the Company’s care governance framework, in which service user safety incidents are investigated and analysed, to identify what can be done to prevent their recurrence. It is a system of accountability to ensure that these changes are implemented, and their effectiveness reviewed. Findings are disseminated to employees so they can learn from service user safety incidents. Audits are an integral process, to monitor the implementation and effects of changes in practice following a service user safety incident.

## **9. Principle of Confidentiality**

Details of a service user safety incidents should always be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the staff involved in treating the service user. The Service provider will anonymise any incident it publishes but still seek the agreement of those involved.

Where it is not practicable or an individual refuses consent to disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the service user safety event have statutory powers for obtaining information. Communications with parties outside of those involved in the investigation will be on a strictly need to know basis. Where possible, it is good practice to inform the service user, their family and carers about who will be involved in care.

## **10. Principle of Continuity of Care**

Service users will continue to receive all usual care and support and continue to be treated with respect and compassion.