



NEW DIRECTION SUPPORT

DUTY OF CANDOUR

Name: New Direction Support

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Policy Statement

The policy should be read in conjunction with the following policies:

- Accessible Information and Communication
- Dignity and Respect
- Good Governance and Quality
- Notifications

This is a requirement under the Fundamental Standards Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 20: Duty of candour - Care Quality Commission (cqc.org.uk).

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 are not risk-free and evidence heard at the 2014 Dalton Review confirmed what was already known.

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

- To be told honestly what 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 (CQC).

The duty applies to all cases of 'significant harm'. This new composite classification would cover the requirements of the reporting duty for NHS and social care providers currently in place with the CQC. 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 to the CQC.

The Policy

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 to support good compassionate care, but they can never serve as a substitute. Achieving candour is about engaging hearts and minds and creating a culture that nurtures it. Important as it may be, a compliance-focused approach is not the best way to begin the journey. 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 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. Hence, the government's choice of a statutory duty sends an unequivocal signal to the health and social care sector that this matters.

Moderate harm means harm that requires a moderate increase in treatment and significant but not permanent harm. A moderate increase in treatment means an unplanned return to surgery, unplanned readmission, prolonged episode of care, extra time in hospital or as an outpatient, and cancelling of treatment care transfer to another treatment area (such as intensive care).

A **notifiable safety incident** is 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, or
- Severe harm, moderate harm, prolonged psychological harm, moderate increase in treatment or prolonged pain to the Service User: (These definitions of harm are linked to the National Reporting and Learning System (NRLS) definitions)
- 'Prolonged psychological harm' means psychological harm that a Service User has experienced or is likely to experience for a continuous period of at least 28 days.
- '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 resident's illness or underlying condition.
- 'Near misses', the intention of the term "could result in harm" in the definition is not to bring near misses into relevance as notifiable safety incidents but to reflect the harm that is not apparent at the time of the incident but may appear later.

The guidance set out below should be followed to fulfil our duty as a provider.

As soon as reasonably practicable:

- Notify the relevant person that the incident has occurred.
- Provide support to the relevant person, where appropriate, including when informing them of the incident.
- The information should be given in person, when possible.
- An account of the incident should be provided, which is factual at the date of the notification.
- Advise them of the relevant steps or actions that are to be taken.
- Include an apology.
- Record the incident and the 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 include the attempts to engage with them.

In this regulation, relevant person means the Service User or in the following circumstances, a person lawfully acting on their behalf (this would only be someone with a lasting power of attorney or a court-appointed deputy):

- On the death of the Service User,
- Where the Service User is under 16 and not competent to decide about their care or treatment, or
- Where the Service User is 16 or over and lacks capacity about the matter.

‘Apology’ means an expression of sorrow or regret in respect of a notifiable safety incident. It is not an admission to liability but an acknowledgement that something could have gone better. To fulfil the duty of candour, you must apologise for the harm caused, regardless of fault, as well as be open and transparent about what has happened.

‘Notifiable’ means to an external regulator, e.g. CQC, Health and Safety Executive.

Identifying a Notifiable Safety Incident

For an incident to be a notifiable incident it must meet all 3 of the following criteria:

- It must have been unintended or unexpected
- It must have occurred during the provision of an activity regulated by CQC
- In the reasonable opinion of a healthcare professional, already has, or might, result in death or severe or moderate harm to the person receiving care

If the treatment or care provided went as intended, and as expected, an incident may not qualify as a Notifiable Safety Incident, even if harm occurred. This does not mean that known complications or side effects of treatment are always disqualified from being Notifiable Safety Incidents. In every case, the healthcare professionals involved must use their judgement to assess whether anything occurred during the provision of the care or treatment that was unexpected or unintended.

Something can qualify as a notifiable safety incident even if the Service User gave consent for a procedure to be carried out. It all depends on the level of harm and whether something unexpected or unintended happened during the care or treatment, regardless of whether consent was given.

If it is discovered a notifiable safety incident occurred under a different care provider, that provider must carry out the notifiable safety incident. However, it is the

responsibility of this organization to be open and transparent with the Service User about what was discovered.

If there are multiple contributors to the harm, they should liaise and work together in the investigation that follows as they would for any other incident. Each organisation still has its own responsibilities under the duty of candour. They must assure themselves that they have met them.

The presence or absence of fault on the part of a provider has no impact on whether or not something is defined as a notifiable safety incident. Saying sorry is not admitting fault.

Reasonable Support

‘Reasonable support’ will vary with every situation, but could include, for example:

- Environmental adjustments for someone who has a physical disability
- An interpreter for someone who does not speak English well
- Information in accessible formats
- Signposting to mental health services
- The support of an advocate, drawing their attention to other sources of independent help and advice such as AvMA (Action against Medical Accidents) or Cruse Bereavement Care

If the relevant person consents, the organisation would involve family members and carers in any discussions, taking reasonable steps to ensure communication is in a way that is as accessible and supportive as possible.

Next of Kin (NOK)

This term is commonly used and there is a presumption that the person identified has certain rights and duties.

Health and social care colleagues should always consult the people closest to a person who lacks the capacity to understand that person’s wishes and feelings to help them make a decision in that person’s best interest.

However, the person identified as NOK should not be asked to sign and/or consent to certain interventions, unless they have a legal basis for doing so, such as an enduring power of attorney (EPA) or the appropriate lasting power of attorney (LPA) for health and welfare. This is a mistake often made in many health and social care settings where family members are asked to sign care plans or end-of-life plans and other treatment options and provide consent that is not legally valid.

Records

The organisation will keep clear records showing responses to notifiable safety incidents. If the incident also meets the notification thresholds it will be reported through the CQC notification system. If the relevant person cannot be or refuses to be contacted, a written record of all attempts to make contact will be kept and the incident reported through the appropriate notifications system and investigated to prevent harm occurring to others.

Related Guidance

CQC Regulation 20: Duty of Candour:

<https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour>

CQC Notifications

<https://www.cqc.org.uk/guidance-providers/notifications>

NMC:

<https://www.nmc.org.uk/standards/guidance/the-professional-duty-of-candour/read-the-professional-duty-of-candour/>

Training Statement

The management needs to be fully aware of this legal duty and it will be incorporated into Induction and a separate briefing will be in place for all managers involved in good governance within their job role. All staff, during induction, are made aware of the organisation's policies and procedures, all of which are used for training updates. All policies and procedures are reviewed and amended where necessary, and staff are made aware of any changes. Observations are undertaken to check skills and competencies. Various methods of training are used, including one-to-one, online, workbooks, group meetings, and individual supervision. External courses are sourced as required.

This policy will be reviewed by the Registered Manager.

Signed:

Date: 9th March 2026

Review Date: 9th March 2029

Appendix One

Duty of Candour Flowchart (Organisation Name)

