NHS
Yorkshire
Ambulance Service
NHS Trust

Being Open (Duty of Candour) Policy

Document Author:
Head of Investigations and Learning / Patient Safety Specialist

Date Approved: February 2025

Document Reference	PO- Being Open (Duty of Candour) Policy – Feb 2028
Version	V13.0
Responsible Director (title)	Executive Director of Quality & Chief Paramedic
Document Author (title)	Head of Investigations & Learning
Approved By	Clinical Governance Group
Date Approved	February 2025
Review Date	February 2028
Equality Impact Assessed (EIA)	Yes
Document Publication	Internal and Public Website.

Document Control Information

Version	Date	Author	Status (A/D)	Description of Change
6.0	5 Dec 2013	Hester Rowell, Head of Quality & Patient Experience	A	Approved SMG
7.0	29 Oct 2014	Gareth Flanders Head of Quality	D	Additional review in light of consultation document Duty of Candour: Agreed at Clinical Governance Group 3 December 2014
8.0	Dec 2014	Gareth Flanders Head of Quality	A	Approved TMG 17 December 2014
9.0	April 2016	Rebecca Mallinder, Head of Investigations & Learning	A	Review following amendments to process and to ensure process in line with statutory and contractual duties.
10.0	Feb 2018	Rebecca Mallinder, Head of Investigations & Learning	A	Approved TMG Feb 2018
11.0	April 2020	Simon Davies, Safety Governance Manager	A	Approved TMG April 2020 – Amended Post Holders
12.0	June 2022	Risk Team	A	Approved at TMG
12.1	July 2023	Risk Team	A	TMG approved extension until December 2023
12.2	May 2024	Risk Team	A	Formatted to Trust new template. Extension approved within April Clinical Governance Group.
12.3	Jan 2025	Risk Team	A	Extension agreed in CGG for 3 months
12.4	Dec 2024	Simon Davies	D	Update to job titles and refresh of information throughout policy. Update Policy template.
12.5	Feb 2025	Simon Davies	D	Reviewed at CQDF
13.0	Feb 2025	Risk Team	A	Policy approved at CGG.
A = Approved D = Draft				
Document Author = Simon Davies (Head of Investigations and Learning)				
Associated Documentation: ▪ Incident Management Policy ▪ Complaints, Concerns, Compliments, Comments Policy ▪ Claims Management Policy ▪ Learning from Deaths Policy ▪ Courts and Evidence Policy ▪ Disclosure Policy				

Staff Summary

Robert Francis QC's report of the Mid Staffordshire Foundation Trust Public Inquiry included 12 recommendations relating to openness, transparency and candour.
In 2008, Regulation 20 of the Health and Social Care Act stated that: "Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity."
The Care Quality Commission (CQC) oversee the statutory requirements for Duty of candour through Regulation 20.
The purpose of this Policy is to ensure that YAS has a clear system in place to identify when the Trust needs to be open about incidents where harm or potential for harm has occurred (including near misses).
'Notifiable safety incident' is a specific term defined in the Duty of candour regulation. It should not be confused with other types of safety incidents or notifications. A notifiable safety incident must meet all 3 of the following criteria: 1. It must have been unintended or unexpected. 2. It must have occurred during the provision of an activity we regulate. 3. 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. This element varies slightly depending on the type of provider.
As soon as is 'reasonably practicable' after becoming aware of the incident the 'registered person' or delegated responsible person must notify the 'relevant person'.
The CQC has the power to bring a criminal prosecution against the organisation if it identifies that the Duty of Candour is breached. A prosecution can cause significant reputational damage for Trusts and attract further scrutiny from the CQC.
Lessons learned and action plans following the patient safety incident will be monitored via the processes outlined in the Incident Management Policy. Learning arising from the Duty of Candour process will be recorded on the Datix record and reported to the Executive Director for Quality & Chief Paramedic when appropriate.
All staff will be made aware of the Trust's Being Open (Duty of Candour) Policy through corporate induction and basic training. This will be part of the Trust's efforts to build a Just & learning culture of openness, honesty, truthfulness and transparency. Those who actively take part in 'being open' meetings with families will also receive additional training and guidance on how to do this, particularly where there is bad news being delivered.
The Duty of Candour process, whilst owned by the Patient Safety Team will be worked collaboratively where appropriate to satisfy 'being open' principles with families and carers as part of other internal processes such as the mortality review, complaint handling and investigations undertaken for HM Coroner.

1.0 Introduction

1.1 Duty of candour is the act of being honest with patients, their families or relevant persons when avoidable harm has; or potentially has happened in our care. It underpins a safety culture which exonerates blame and focuses on learning: leading to improved patient outcomes and patient experience.

1.2 From 2013-14 the NHS Standard Contract (NHS Commissioning Board, 2013) includes a contractual duty of candour. These requirements are covered within this policy.

In 2008, Regulation 20 of the Health and Social Care Act stated that: “Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.”

1.3 Following the Francis Inquiry in 2013, which found serious failings in openness and transparency at Mid Staffordshire NHS Foundation Trust, the statutory duty of candour was passed into law in 2014 for all NHS Trusts, and 2015 for all other providers of health and social care.

1.4 The statutory duty of candour is fundamentally linked to the concepts of openness and transparency that often policies and procedures related to it have come to be known by colleagues by other names such as “Being Open”, “Saying Sorry”, and “Just Culture.”

1.5 The Care Quality Commission (CQC) oversee the statutory requirements for duty of candour through Regulation 20.

1.6 In March 2021, the CQC published their updated guidance following a public consultation in 2018. People shared examples of positive and negative experiences surrounding duty of candour. They referred to “cover ups” – whether real or perceived, and that the lack of an apology compounded the level of harm that they had experienced following the initial incident. This is frequently cited as “secondary trauma” in related literature.

1.7 However, when the duty of candour had been carried out well, people felt that they had received a “heartfelt apology”, that the care provider had been “honest from the outset”, that “it was not a tick-box exercise”, and there was learning assurance that measures had been put in place to prevent the incident from happening to others.

1.8 There is also a professional duty of candour which is regulated by professional bodies including the General Medical Council (GMC), the General Dental Council (GDC) and the Nursing and Midwifery Council (NMC).

1.9 Duty of candour is strongly aligned to “The Seven Principles of Public life” which were set out by Lord Nolan in his report to the Committee on Standards in Public life in 1995. They outline the ethical standards for those people working in the public sector and are expected to be adhered to.

The seven principles are:

- **Selflessness**
- **Integrity**
- **Objectivity**
- **Accountability**
- **Openness**
- **Honesty**
- **Leadership**

2.0 Purpose/Scope

2.1 The purpose of this Policy is to ensure that YAS has a clear system in place to identify when the Trust needs to be open about incidents where harm or potential for harm has occurred (including near misses). Discussing patient safety incidents promptly, fully and compassionately can help patients and professionals to cope better with the after-effects. Openness and honesty can help to prevent such events becoming formal complaints and litigation claims.

2.2 This Policy applies to all patient safety incidents that occur during care and associated activities carried out by Yorkshire Ambulance Service NHS Trust that result in harm, or possible future harm and where a notifiable safety incident has occurred and has been identified using the flow chart for decision making at Appendix E, taken from the following guidance: https://www.cqc.org.uk/guidance-providers/all-services/regulation-20-duty-candour

3.0 Process

Principles for Duty of Candour

3.1 There are two elements to the Duty of Candour principles in order to satisfy both the professional duty and the statutory duty.

Both the statutory duty of candour and professional duty of candour have similar aims – to make sure that those providing care are open and transparent with the people using their services, whether or not something has gone wrong.

Under the statutory duty of candour, the Trust is required to comply with obligations regarding candour if a notifiable safety incident occurs or is suspected to have occurred.

A notifiable safety incident can be defined as:

'Notifiable safety incident' is a specific term defined in the duty of candour regulation. It should not be confused with other types of safety incidents or notifications.

A notifiable safety incident must meet all 3 of the following criteria:

1. It must have been unintended or unexpected.

2. It must have occurred during the provision of an activity we regulate.

3. 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. This element varies slightly depending on the type of provider'

3.2 Providers are required to maintain a 'registered person' or persons responsible for carrying out or delegating responsibility for carrying out the duty.

As soon as is 'reasonably practicable' after becoming aware of the incident the 'registered person' or delegated responsible person must notify the 'relevant person'.

Notification must include the following items:

1. Tell the relevant person, face-to-face, that a notifiable safety incident has taken place.
2. Apologise.
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain to the relevant person what further enquiries or investigations you believe to be appropriate.
5. Follow up by providing this information, and the apology, in writing, and providing an update on any enquiries.
6. Keep a secure written record of all meetings and communications with the relevant person.

3.3 The CQC has the power to bring a criminal prosecution against the organisation if it identifies that the Duty of Candour is breached. A prosecution can cause significant reputational damage for Trusts and attract further scrutiny from the CQC.

3.4 The statutory duty imposes similar implications on the organisation however does not hold the timescales that are enforced through the contract. It also requires that organisations offer reasonable support to those involved in the incident in contrast to the contractual duty which requires all necessary support will be given. Both the professional and the statutory duties fundamentally require Yorkshire Ambulance Service NHS Trust to act in an open, honest and transparent manner with patients and others involved in a notifiable safety incident.

3.5 Families and carers have a right to be involved in investigations if they wish to do so. The Trust will accommodate this and ensure that all relevant questions of the family are built into the investigation and that they have input into it.

3.5b Throughout the process the Trust must give 'reasonable support' to the relevant person, both in relation to the incident itself and when communicating with them about the incident. '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) AvMA or Cruse Bereavement Care Home - Cruse Bereavement Support

Practical guidance

3.7 The process is managed by the Quality & Safety Team with the Head of Investigations & Learning being the Trust's 'Responsible Person'. No written correspondence should be issued under the being open principles unless it has been coordinated and approved by the Head of Investigations & Learning (or appropriate deputy).

3.8 The Quality & Safety Team (or Integrated Urgent Care (IUC) Governance Team for cases involving their service line) will keep full records of all correspondence, written and verbal, with the patient and/or others involved in the incident. These will be recorded on the Datix record for each case. A Duty of Candour log is also utilised to track progress of cases with full information being available on the Datix record. This will include an archive of all closed cases.

3.9 Lessons learned and action plans following the patient safety incident will be monitored via the processes outlined in the Incident and Serious Incident Management Policy. Learning arising from the Duty of Candour process will be recorded on the Datix record and reported to Quality Committee via dashboard.

Principles of Communication

- Patients and/or their carers/families/appointed advocate, relevant staff members or representatives will be given a single point of contact from the quality & professional standards team (ideally a family and staff engagement officer) for any questions or requests they may have throughout the process.

- Patients and/or their carers/families/appointed advocate or representatives will be offered a sincere apology as soon as possible following identification of the incident, using principles highlighted in the NHS Resolution 'saying sorry' guide 2023 (appendix C).

- Patients and/or their carers/families/appointed advocate, relevant staff members or representatives will receive clear, unambiguous information which is free from medical jargon.

- Communication, including written communications will be tailored to the specific requirements and preferences of the individual and conform to Plain English standards as a minimum.

- Where an individual requires additional support, such as a translator, interpreter independent advocate or use of alternative methods of communication such as audio-recording or Braille, all reasonable measures will be taken to accommodate these requirements.

- All communications and records will be carried out and handled with full regard for patient confidentiality. Information will only be disclosed to third parties with the appropriate patient/next-of-kin consent.

3.10 The quality & professional standards team will work alongside colleagues from other directorates particularly the 'Clinical Team' and 'Legal Services' to ensure all families are supported when there is a death in YAS' care. This may be identified via the mortality review process or via a request from a Medical Examiner or HM Coroner. The same level of involvement and support to relatives must be offered. Details of how this will be applied in practice will be covered within associated policies on the above processes.

3.11 Where there is a complaint that identifies that moderate or above harm has been caused to a patient, actionable elements of the Duty of Candour procedure will remain with the Patient Relations team as part of the complaint handling processes.

4.0 Training expectations for staff

4.1 All staff will be made aware of the Trust's Being Open (Duty of Candour) Policy through corporate induction and mandatory training. This will be part of the Trust's efforts to build a Just culture of openness, honesty, truthfulness, and transparency. Information on this policy and process will also be covered as part of future investigations training materials.

4.2. Staff within the Quality and Professional Standards Directorate will receive guidance and support relating to their roles to ensure that they are able to carry out their duties effectively. The Deputy Director of Quality will ensure that this guidance and support is in place, including arranging provision for colleagues to attend bespoke Family Liaison training where available.

4.3 Senior managers responsible for taking part in 'being open' meetings will receive guidance and support on carrying out these responsibilities. This will be provided by (or on behalf of) the Head of Investigations & Learning.

4.4 All Trust staff will be expected to complete level 1 of the NHS England 'Patient Safety Syllabus', with level 2 being available for personal study. Colleagues in the Quality and Professional Standards directorate will be offered support to complete further enhanced study as and when it becomes available.

5.0 Implementation Plan

5.1. The following stakeholders have been consulted (directly or via working group) in the development, consultation, and review of this policy:

Clinical Quality Development Forum (CQDF)	Clinical Governance Group (CGG)	Legal Services Manager
Patient Relations Manager	Head of Risk and Assurance & Data Protection Officer	Head of Investigations and Learning
Family and Staff Engagement Officer	Deputy Director for Quality and Nursing	Head of Nursing and Patient Experience
Caldicott Guardian	[redacted]	

5.2. The policy has been reviewed by members of the Clinical Governance Group and approved.

5.3 The latest approved version of this Policy will be posted on the Trust Intranet site for all members of staff to view. New members of staff will be signposted to how to find and access this guidance during trust induction.

5.4. Archived documents will be stored electronically within the Document Library archive. A copy of previous versions of the policy will be additionally held by the policy author.

6.0 Monitoring compliance with this Policy

6.1 The YAS 'Being Open' log will maintain an up-to-date record of all current and archived cases of moderate harm, severe harm or death. Full details can be accessed via the Datix records.

6.2 Data relating to duty of candour will be published via an oversight dashboard to inform the Quality Committee.

6.3 An audit will be undertaken on behalf of the Head of Investigations & Learning weekly, monthly and quarterly to ensure that all patient safety incidents with moderate or above recorded harm have been subject to the being open process.

7.0 References

- Being Open – Communicating patient safety incidents with patients, their families and carers, National Patient Safety Agency, London, 2009.
- Report of the Mid-Staffordshire NHS Foundation Trust Public Enquiry, Robert Francis QC, February 2013, HHC 947, London: The Stationary Office.
- Technical Guidance to NHS Contract 2013-14, Annex 4, available at: http://www.england.nhs.uk/wp-content/uploads/2013/02/contract-tech-guide.pdf

- Health and Social Care Act 2008 (Duty of Candour) Regulations 2014

- CQC 2015. Regulation 20: Duty of candour. Information for providers: NHS Bodies, adult social care, primary medical and dental care and independent healthcare. Regulation 20: Duty of candour | Care Quality Commission (cqc.org.uk)

- https://www.cqc.org.uk/sites/default/files/2022-12/20220722-duty-of-candour-pdf-version-FINAL-2.pdf

- Learning from Deaths guidance, National Quality Board (2019)

- Learning from Deaths guidance for NHS Trusts on Working with Bereaved Families and Carers, NHS England (2018)

- NHS England & Improvement – Patient Safety Incident Response Framework (PSIRF) NHS England » Patient Safety Incident Response Framework

- NHS England – Patient Safety Syllabus (2021) NHS Patient Safety Syllabus training - elearning for healthcare (e-lfh.org.uk)

- NHS Resolution – Saying Sorry (2023) Read saying sorry (duty of candour) - NHS Resolution

- NHS England – Just Culture guide (2018) NHS England » A just culture guide

- NOLAN The seven principles of public life, the Committee on standards in public life (1995) The Seven Principles of Public Life - GOV.UK (www.gov.uk)

8.0 Appendices

8.1 The following appendices are included within the policy:

Appendix A – Definitions

Appendix B – Roles & Responsibilities

Appendix C – NHS Resolution ‘Saying Sorry’ October 2023

Appendix D – Care Quality Commission – The duty of candour: Guidance for providers (Identifying a notifiable safety incident)

Appendix A - Definitions

Apology

Expression of sorrow or regret in respect of a notifiable safety incident.

Notifiable Safety Incident

‘Notifiable safety incident’ is a specific term defined in the duty of candour regulation. It should not be confused with other types of safety incidents or notifications.

A notifiable safety incident must meet all 3 of the following criteria:

1. It must have been unintended or unexpected.
2. It must have occurred during the provision of an activity we regulate.
3. 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. This element varies slightly depending on the type of provider.

The definitions of harm vary because when the regulation was written, harm thresholds were aligned with existing notification systems to reduce the burden on providers. It is possible for an incident to trigger the harm threshold for NHS trusts, but not for other service types, or vice versa.

No harm

Incident prevented – any patient safety incident that had the potential to cause harm but was prevented, and no harm was caused to patients receiving NHS-funded care.

Incident not prevented – any patient safety incident that occurred but no harm was caused to patients receiving NHS-funded care.

Low Harm

Any patient safety incident that required extra observation or minor treatment and caused minimal harm to one or more patients receiving NHS-funded care.

Minor treatment is defined as first aid, additional therapy, or additional medication. It does not include any extra stay in hospital or any extra time as an outpatient, or continued treatment over and above the treatment already planned; nor does it include a return to surgery or readmission.

Moderate Harm

Harm that requires a moderate increase in treatment and significant, but not permanent, harm

Severe Harm

A permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.

Moderate increase in treatment

An unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care).

Death

Any patient safety incident that directly resulted in the death of one or more patients receiving NHS-funded care.

The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.

Prolonged Pain

Pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

Prolonged Psychological Harm

Psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

Relevant Person

The service user or in the following circumstances, a person lawfully acting on their behalf –

a) on the death of the service user, where the service user is under 16 and not competent to make a decision in relation to their care or treatment, or
b) where the service user is 16 or over and lacks capacity (as determined in accordance with the Mental Capacity Act 2005 in relation to the matter.

Registered Person

The 'registered person' is responsible for carrying out, or delegating the responsibility for carrying out, the duty and must liaise with the 'relevant person'.

The ‘registered person’ is the registered manager or the registered provider.

At Yorkshire Ambulance Service NHS Trust – This is the Chief Executive Officer (CEO)

Responsible Person

The ‘responsible person’ is the person best placed within the Trust to carry out the duty on behalf of the ‘registered person’

At Yorkshire Ambulance Service NHS Trust – This is the Head of Investigations and Learning (HOIL) or nominated Patient Safety Specialist (PSS).

‘Face to Face’

In order to meet the requirements under regulation 20, Trust representatives will be guided by patients and/or their carers/families/appointed advocate or representatives in discussion regarding how they wish to engage which may include (but not be limited too) telephone, written letter, face to face meeting, digital communications such as video conferencing/instant messaging services/recorded digital media.

Appendix B - Roles & Responsibilities

The Trust Board is responsible for:

- Establishing a culture of openness and candour and making a public commitment to the principles of Being Open.

The Quality Committee is responsible for:

- Gaining assurance that the Policy on Being Open & Duty of Candour is being delivered effectively in practice.

The Caldicot Guardian is responsible for:

- Supporting decision making around complex/ethically complex cases.

The Central Incident Review Group is responsible for:

- Maintaining an overview of all Being Open cases and agreeing the decisions and proposed course of action.

- Supporting those involved in Being Open cases with clinical expertise and/or best practice on management of meetings.

- Highlighting cases not automatically within the Being Open system (i.e. those graded as Yellow or Green through the Trust Risk Management Procedures) which should be considered for Being Open.

- Closing Being Open cases at the appropriate stage of the process i.e. when contact has been made, findings shared and no further action required or when contact has not been established despite reasonable attempts being made by YAS.

All Staff

- Be aware and act upon guidance as outlined in this policy
- Identify potential incidents and report though agreed processes
- Provide statements if required and participate in some feedback to patients where appropriate.
- At all times, act in an honest and transparent way.

Executive Director of Quality & Chief Paramedic is responsible for:

- Being the ultimate lead within the Trust for Duty of Candour.

- Chairing the Central Incident Review Group, reviewing notifiable safety incidents and confirming that agreed actions and next steps for current patient safety incidents are in line with this policy.

- Ensuring that the Being Open (Duty of Candour) Policy is fully integrated with other policies, specifically clinical governance risk management and complaints/concerns policies.

- Through attendance at the Central Incident Review Group, reviewing the notifiable safety incidents and confirming that agreed actions and next steps in line with this policy.

- Being accountable for decisions made in relation to the Duty of Candour process.

Head of Investigations & Learning is responsible for:

- Acting as the 'Responsible Person' and Trust lead for Being Open for the management and application of the policy and representing the Trust with correspondence with relevant persons.

- Receiving notification of all new notifiable safety incidents resulting in moderate harm, severe harm or death and identifying how YAS will discharge its responsibility under this policy.

- Ensuring that each case has a nominated individual to act as a single point of contact and that communications are carried out by appropriately qualified and trained individuals.

- Ensuring that learning from Being Open cases is identified, triangulated with other sources of information and used to reduce future patient harm and inform the future development of this policy.

- Ensuring that staff involved in the Being Open process have the necessary skills and training to carry out their roles.

- Ensuring that there is an awareness by all Trust staff of the Duty of Candour and what this means in practice for working with honesty, openness and truthfulness.

- Presenting the Duty of Candour updates to the Trust Learning Group (TLG) and highlighting any cases that require discussion and action.

- Escalating any concerns relating to the Duty of Candour application to the Executive Director of Quality and Chief Paramedic.

- Reporting to the commissioners under the standard contract updates on the Duty of Candour including any exceptions to the application of this process.

Family and Staff Engagement Officer is responsible for:

- Maintaining the Duty of Candour log and the Datix records for each notifiable safety incident in relation to Duty of Candour application.

- Maintaining an archive of closed Being Open cases.

- Ensuring that full records are kept, and are accessible to appropriate parties, of Being Open cases.

- Acting as the single point of contact for the relevant persons throughout the Duty of Candour process where identified as appropriate.

Appendix C – NHS Resolution 'Saying Sorry' Published October 2023

NHS Resolution

Saying sorry

Saying sorry meaningfully when things go wrong is vital for everyone involved in an incident, including the patient, their family, carers, and the staff that care for them.

Saying sorry is:

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

Why?

Not only is it a moral and right thing to do – it is also a statutory, regulatory, and professional requirement. It can also support learning and improve patient* safety.

When?

As soon as possible after you become aware something has gone wrong you should seek out the patient and or their family and say sorry and acknowledge what has happened and tell them that you will find out more. Reassure them that you will keep them informed.

Who?

Everyone can say sorry, but you may need to be supported to do so. You may need the backing of more senior people and staff may need training but it should not stop you from simply saying sorry.

As part of an initial apology it is best practice to provide the patient and their family with a key contact wherever possible.

What if there is a formal complaint or claim?

The Compensation Act 2006 states; 'An apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty'. (source: Compensation Act 2006 – Chapter 29 page 3)

In fact, delayed or poor communication makes it more likely that the patient will seek information in a different way such as complaining or taking legal action. The existence of a formal complaint or claim should never prevent or delay you saying sorry.

How?

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 recognising complications referred to in the consent process. It should be confidential and tailored to the individual patient's needs.

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.

It is the starting point of a longer conversation; as over time this will lead to sharing information about what went wrong and what you will do differently in the future. It is vital to avoid acronyms and jargon in all communications.

* The word 'patient' is a term used here for simplicity and may more appropriately refer to a parent, baby, carer, family member or claimant

You may also need to say sorry in writing where significant harm has been caused or in response to a written complaint. An example of this could be:

"I wish to assure you that I am deeply sorry for the poor care you have been given and that we are all truly committed to learning from what happened. I apologise unreservedly for the distress this has caused you and your family"

What about the statutory Duty of Candour?

The statutory Duty of Candour is laid out in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It puts an overarching legal duty on health and social care providers to be open and transparent with people using services, and their families, in relation to their treatment or care. It is overseen by the Care Quality Commission (CQC).

As well as the overarching duty, regulation 20 also sets out some **specific actions** that providers must take when a notifiable safety incident occurs.

These steps include informing people about the incident, providing reasonable support, truthful information and an apology. Saying sorry forms an integral part of this. Process should never stand in the way of providing a full explanation when something goes wrong.

Don't say	Do say
x I'm sorry you feel like that	✓ I'm sorry X happened
x We're sorry if you're offended	✓ We're truly sorry for the distress caused
x I'm sorry you took it that way	✓ I'm sorry, we have learned that...
x We're sorry, but...	

"We have never, and will never, refuse cover on a claim because an apology has been given."

Helen Vernon, Chief Executive, NHS Resolution

The NHS Constitution

Patients: "you have the right to an open and transparent relationship with the organisation providing your care. You must be told about any safety incident relating to your care which in the opinion of a healthcare professional, has caused or could still cause significant harm or death. You must be given the facts, an apology, and any reasonable support you need".

Staff: "you should aim to be open with patients… if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in the spirit of cooperation."

Further resources

Duty of Candour animation
resolution.nhs.uk/resources/duty-of-candour-animation/

Being fair and Being fair 2 reports
resolution.nhs.uk/resources/being-fair-report/

resolution.nhs.uk/resources/being-fair-2/

For more information

Nursing and Midwifery Council & General Medical Council joint guidance on openness and honesty when things go wrong
gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/candour---openness-and-honesty-when-things-go-wrong

Reports and consultations on complaint handling (Parliamentary and Health Service Ombudsman)
ombudsman.org.uk/publications

AvMA (Action against Medical Accidents) Duty of Candour leaflet
avma.org.uk/policy-campaigns/duty-of-candour/duty-of-candour-leaflet

Care Quality Commission - Regulation 20: Duty of Candour
cqc.org.uk/content/regulation-20-duty-candour

Harmed Patients Alliance
harmedpatientsalliance.org.uk

If you want to get in touch nhsr.safety@nhs.net

Published October 2023

Appendix D – CQC Duty of Candour Guidance for Providers, Identifying a notifiable safety incident.