Nursing & Midwifery Council

General Medical Council

Professional standards

In effect: 29 June 2015

Openness and honesty when things go wrong: The professional duty of candour

Summary

In this joint guidance with the Nursing and Midwifery Council (NMC) we explore what being open and honest about mistakes means in practice. And whose responsibility it is to explain and record what has gone wrong.

We include practical advice on:

- when and who you should apologise to
- what to include in an apology
- how to say sorry.

There is also a section on encouraging you to report errors, not only with your patients, but at your place of work to help promote a learning culture.

General Medical Council

Openness and honesty when things go wrong: The professional duty of candour

Professional standards: More detailed guidance

This guidance came into effect on 29 June 2015

This guidance was last updated on 13 December 2024

You can find the latest version of all our professional standards at www.gmc-uk.org/guidance.

Contents

The professional duty of candour

Every health and care professional must be open and honest with patients and people in their care when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.[1] This means that health and care professionals must:

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

Health and care professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns.

[1] General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland (2014) Joint statement from the Chief Executives of statutory regulators of healthcare professionals (accessed 17 January 2022). Please note that, in this section of the GMC-NMC guidance, some stylistic changes have been made to the text of the original 2014 joint statement.

About our Candour guidance

1. When we refer to 'patients' in this guidance, we also mean people who are in your care.

2. All health and care professionals have a duty of candour – a professional responsibility to be honest with patients when things go wrong. This is described in *The professional duty of candour*, which introduces this guidance.

3. As a doctor, physician associate, anaesthesia associate, nurse, midwife or nursing associate, you must be open and honest with patients, colleagues and your employers.

4. This guidance gives more information about how to follow the principles set out in *Good medical practice*[2]and *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*.[3] Appendix 1 sets out relevant extracts from General Medical Council (GMC) and Nursing and Midwifery Council (NMC) standards and guidance. The GMC's guidance applies to all doctors, physician associates and anaesthesia associates (collectively referred to as medical professionals and whom we address directly as 'you' throughout the guidance) registered with it; the NMC's standards and guidance apply to all nurses, midwives and nursing associates registered with it.

   As with all our professional standards, the guidance applies to all our registrants to the extent that it is relevant to the individual's practice.

5. This guidance is divided into two parts:

   a. Your duty to be open and honest with patients in your care, or those close to them, if something goes wrong. This includes advice on apologising (paragraphs 7 - 22).

[2] General Medical Council (2024) *Good medical practice* (accessed 31 January 2024), paragraphs 76 and 45. The GMC's professional standards describe good practice, and not every departure from them will be considered serious. You must use your professional judgement to apply the standards to your day-to-day practice. If you do this, act in good faith and in the interests of patients, you will be able to explain and justify your decisions and actions. We say more about professional judgement, and how the professional standards relate to the GMC's fitness to practise processes, appraisal and revalidation, at the beginning of *Good medical practice*.

[3] Nursing and Midwifery Council (2018) *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates* (accessed 17 January 2022), section 14

b. Your duty to be open and honest with your organisation, and to encourage a learning culture by reporting adverse incidents that lead to harm, as well as near misses (paragraphs 23 - 29).

6. This guidance is for individuals. We recognise that care is normally provided by multidisciplinary teams, and we don't expect every team member to take responsibility for reporting adverse incidents and speaking to patients if things go wrong. However, we do expect you to make sure that someone in the team has taken on responsibility for each of these tasks, and we expect you to support them as needed.

Being open and honest with patients in your care, and those close to them, when things go wrong

Discuss risks before beginning treatment or providing care

7. Patients must be fully informed[4] [5] about their care. When discussing care options with patients, you must discuss the risks as well as the benefits of the options.

8. You or an appropriate person[6] must give the patient clear, accurate information about the risks of the proposed treatment or care, and the risks of any reasonable alternative options, and check that the patient understands. You should discuss risks[7] that occur often, those that are serious even if very unlikely, and those that the patient is likely to think are important.[8]

In what circumstances do I need to apologise to the patient?

[4] General Medical Council *Decision making and consent* (2020)

[5] Nursing and Midwifery Council (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (accessed 17 January 2022), section 4.2

[6] General Medical Council (2020) *Decision making and consent* , paragraphs 42-45

[7] General Medical Council (2020) *Decision making and consent*, paragraphs 12, 17-24, 27-30, 66-67 and 58f.

[8] The Supreme Court (2015) Judgment: Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) (accessed 17 January 2022), paragraphs 86–91

9. This guidance is not intended for circumstances where a patient's condition gets worse due to the natural progression of their illness. It applies when something goes wrong with a patient's care, and they suffer harm or distress as a result. This guidance also applies in situations where a patient may yet suffer harm or distress as a result of something going wrong with their care.

10. When you realise that something has gone wrong, and after doing what you can to put matters right, you or someone from the healthcare team must speak to the patient.[9] The most appropriate team member will usually be the lead or accountable clinician.[10] If this is not you, then you must follow the guidance in paragraph 6.

When should I speak to the patient or those close to them, and what do I need to say?

11. You should speak to the patient as soon as possible after you realise something has gone wrong with their care. When you speak to them, there should be someone available to support them (for example a friend, relative or professional colleague). You do not have to wait until the outcome of an investigation to speak to the patient, but you should be clear about what has and has not yet been established.

12. You should share all you know and believe to be true about what went wrong and why, and what the consequences are likely to be. You should explain if anything is still uncertain and you must respond honestly to any questions.[11] You should apologise to the patient (see paragraphs 14-20).

What if people don't want to know the details?

13. Patients will normally want to know more about what has gone wrong. But you should give them the option not to be given every detail. If the patient does not want more information, you should try to find out why. If after discussion, they don't change their mind, you should

[9] If the patient has died, or is unlikely to regain consciousness or capacity, 'patient' in paragraph 10-17 should be read as 'those close to the patient'.

[10] General Medical Council (2014) *Guidance for doctors acting as responsible consultants or clinicians* (accessed 17 January 2022)

[11] General Medical Council (2024) *Good medical practice* (accessed 14 January 2024), paragraph 3.

respect their wishes as far as possible,[12] having explained the potential consequences. You must record the fact that the patient does not want this information and make it clear to them that they can change their mind and have more information at any time.

Saying sorry

14. Patients expect to be told three things as part of an apology:

    a. what happened
    b. what can be done to deal with any harm caused
    c. what will be done to prevent someone else being harmed.

15. Apologising to a patient does not mean that you are admitting legal liability[13] for what has happened. This is set out in legislation in parts of the UK[14] and NHS Resolution also advises that saying sorry is the right thing to do.[15] In addition, a fitness to practise panel may view an apology as evidence of insight.[16, 17]

16. When apologising to patients and explaining what has happened, we do not expect you to take personal responsibility for something going wrong that was not your fault (such as system errors or a colleague's mistake). But the patient has the right to receive an apology from the most appropriate team member (see paragraph 10), regardless of who or what may be responsible for what has happened.

17. We do not want to encourage a formulaic approach to apologising since an apology has value only if it is genuine. However, when apologising to a patient, you should consider each of the following points.

[12] If the patient needs to give their consent to a proposed investigation or treatment, then you need to give them enough information to make an informed decision.

[13] 'Legal liability' here refers to a clinical negligence claim. NHS Resolution 'will never refuse cover on a claim because an apology has been given'.

[14] Compensation Act 2006 (England and Wales) (accessed 17 January 2022), section 2

[15] NHS Resolution *Saying Sorry* (accessed 17 January 2022)

[16] General Medical Council Sanctions guidance for members of medical practitioners tribunals and for the General Medical Council's decision makers.

[17] Nursing and Midwifery Council (2018) Factors to consider before deciding on sanctions (accessed 17 January 2022)

a. You must give patients the information they want or need to know in a way that they can understand.[18]
b. You should speak to patients in a place and at a time when they are best able to understand and retain information.
c. You should give information that the patient may find distressing in a considerate way, respecting their right to privacy and dignity.
d. Patients are likely to find it more meaningful if you offer a personalised apology – for example 'I am sorry…' – rather than a general expression of regret about the incident on the organisation's behalf. This doesn't mean that we expect you to take personal responsibility for system failures or other people's mistakes (see paragraph 16).
e. You should make sure the patient knows who to contact in the healthcare team to ask any further questions or raise concerns. You should also give patients information about independent advocacy, counselling or other support services[19] that can give them practical advice and emotional support.
f. You should record the details of your apology in the patient's clinical record.[20, 21] A verbal apology may need to be followed up by a written apology, depending on the patient's wishes and on your workplace policy.[22]

Speaking to those close to the patient

18. If something has gone wrong that causes a patient's death or such severe harm that the patient is unlikely to regain consciousness or capacity, you must be open and honest with

[18] General Medical Council (2020) *Decision making and consent*, paragraphs 27-29.

[19] For example, you could direct them to Action against Medical Accidents (AvMA), which works across the UK, or to their local Healthwatch group in England, the Patient and Client Council in Northern Ireland, the Patient Advice and Support Service in Scotland or the Community Health Council in Wales. See Patients' help on the GMC website or Support for patients, families and the public on the NMC website for further information.

[20] General Medical Council (2024) *Good medical practice* (accessed 31 January 2024), paragraph 70

[21] Nursing and Midwifery Council (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (accessed 17 January 2022), section 14.3

[22] See appendix 2 for detail of the statutory duty of candour for organisations providing health and care.

those close to the patient.[3, 23] Take time to convey the information in a compassionate way, giving them the opportunity to ask questions at the time and afterwards.[24]

19. You must show respect for, and respond sensitively to, the wishes and needs of bereaved people. You must take into account what you know of the patient's wishes about what should happen after their death, including their views about sharing information. You should be prepared to offer support and assistance to bereaved people – for example by explaining where they can get information about, and help with, administrative and practical tasks following a death; or by involving other members of the team, such as chaplaincy or bereavement care staff. [25, 26]

20. You should make sure, as far as possible, that those close to the patient have been offered appropriate support, and that they have a specific point of contact in case they have concerns or questions at a later date.

Being open and honest with patients about near misses

21. A 'near miss' is an adverse incident that had the potential to result in harm but did not do so.[27] You must use your professional judgement when considering whether to tell patients about near misses. Sometimes there will be information that the patient needs to know or would want to know, and telling the patient about the near miss may even help their

[23] General Medical Council (2024) *Good medical practice* (accessed 31 January 2024), paragraphs 73,81,88,89.

[24] If a patient has previously asked you not to share personal information about their condition or treatment with those close to them, you should respect their wishes. While doing so, you must do your best to be considerate, sensitive and responsive to those close to the patient, giving them as much information as you can.

[25] The following provide information on where people can find help and support following a bereavement:

- England: Bereavement help and support
- Northern Ireland: Who to tell about a death
- Scotland: Bereavement support
- Wales: What to do after a death

[26] General Medical Council (2010) *Treatment and care towards the end of life: good practice in decision making* (accessed 17 January 2022), paragraph 84

[27] This does not include adverse incidents that may result in harm but have not yet done so – the patient must be told about these events and they must be reported in line with this guidance.

recovery. In these cases, you should talk to the patient about the near miss, following the guidance in paragraphs 11–17.

22. Sometimes failing to be open with a patient about a near miss could damage their trust and confidence in you and the healthcare team. However, in some circumstances, patients may not need to know about an adverse incident that has not caused (and will not cause) them harm, and to speak to them about it may distress or confuse them unnecessarily. If you are not sure whether to talk to a patient about a near miss, seek advice from your healthcare team or a senior colleague.

Encouraging a learning culture by reporting errors

23. When something goes wrong with patient care, it is crucial that it is reported at an early stage so that lessons can be learnt quickly and patients can be protected from harm in the future.

24. All health and care organisations have a duty to support their staff to report adverse incidents. Health and care organisations should have a policy for reporting adverse incidents and near misses, and you must follow your organisation's policy.[28]

25. A number of reporting systems and schemes exist around the UK for reporting adverse incidents and near misses.

    a. Patient safety incidents in England and Wales are reported to the National Reporting and Learning System, or its replacement, the Learn from patient safety events (LFPSE) service.[29,30]
    b. You must use the UK-wide Yellow Card scheme[31] to inform the Medicines and Healthcare products Regulatory Agency (MHRA) about:

        i. serious suspected adverse reactions to a medicine

[28] General Medical Council (2013) *Good medical practice* (accessed 31 January 2024), paragraph 73

[29] NHS England *Report a patient safety incident* (accessed 17 January 2022)

[30] The LFPSE service was launched in July 2021 and will eventually replace the NRLS. During the transition period professionals will need to identify which system their organisation is using to report incidents. Further information on the LFPSE service is available on NHS England and Improvement's website.

[31] The MHRA provides guidance for healthcare professionals, patients and the public on reporting adverse incidents with medicines and medical devices to the Yellow Card scheme.

ii. any suspected adverse reactions to products marked with a Black Triangle symbol (▼).[32]

c. Adverse incidents involving medical devices, including those caused by human error, that put, or have the potential to put, the safety of patients, health and care professionals or others at risk must be reported to the medical device safety lead in your organisation (if there is one) and the relevant national body:

i. in England and Wales - MHRA reporting adverse incidents

ii. in Northern Ireland - Northern Ireland Adverse Incident Centre

iii. in Scotland - Health Facilities Scotland online incident reporting

d. Healthcare Improvement Scotland has a national framework,[33] which aims to support health and social care services in Scotland effectively manage adverse events.

e. The Health and Social Care Board has published a procedure for the reporting and follow-up of serious adverse incidents in Northern Ireland.[34]

f. In England, general practitioners and other primary medical services must submit all notifications[35] directly to the Care Quality Commission (CQC).

26. In addition to contributing to these systems, you should comply with any system for reporting adverse incidents that put patient safety at risk within your organisation. If your organisation does not have such a system in place, you should speak to your manager and – if necessary – raise a concern in line with our guidance.[36, 37]

27. Your organisation has a duty to support you to report adverse incidents and near misses routinely. If you do not feel supported to report, and in particular if you are discouraged or prevented from reporting, you should raise a concern in line with our guidance.[36, 37]

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[32] New medicines and vaccines that are under additional monitoring may be marked with an inverted black triangle symbol (▼). The symbol appears in the British National Formulary (BNF), summaries of product characteristics, patient information leaflets and elsewhere.

[33] Healthcare Improvement Scotland (2019) *Learning from adverse events through reporting and review: A national framework for Scotland* (accessed 17 January 2022)

[34] Health and Social Care Board (Northern Ireland) *Procedure for the Reporting and Follow up of Serious Adverse Incidents* (accessed 17 January 2022)

[35] Registered providers in England are required to notify the CQC about certain incidents. For guidance see CQC's information for providers on Notifications.

[36] General Medical Council (2012) *Raising and acting on concerns about patient safety* (accessed 17 January 2022)

[37] Nursing and Midwifery Council (2018) Raising concerns: guidance for nurses, midwives and nursing associates (accessed 17 January 2022)

28. You must not try to prevent colleagues or former colleagues from raising concerns about patient safety.[38] If you are in a management role, you must make sure that individuals who raise concerns are protected from unfair criticism or action, including any detriment or dismissal.

29. You must take part in regular reviews and audits[39, 40] of the standards and performance of any team you work in, taking steps to resolve any problems. You should also discuss adverse incidents and near misses at your appraisal.[41, 42]

Additional duties for doctors, nurses and midwives with management responsibilities and for senior or high-profile clinicians

30. Senior clinicians have a responsibility to set an example and encourage openness and honesty in reporting adverse incidents and near misses. Clinical leaders should actively foster a culture of learning and improvement.[43, 44]

31. If you have a management role or responsibility, you must make sure that systems are in place to give early warning of any failure, or potential failure, in the clinical performance of individuals or teams. These should include systems for conducting audits and considering patient feedback. You must make sure that any concerns about the performance of an individual or team are investigated and, if appropriate, addressed quickly and effectively.

[38] A fitness to practise panel is likely to consider a more serious sanction if there is evidence of a failure to raise a concern, or of an attempt to cover up.

[39] Nursing and Midwifery Council (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (accessed 17 January 2022), section 23

[40] General Medical Council (2024) *Good medical practice* (accessed 31 January 2024), paragraphs 13 , 73.

[41] General Medical Council (2012) Supporting information for revalidation (accessed 17 January 2022), p8

[42] The Nursing and Midwifery Council provides guidance on revalidation.

[43] Nursing and Midwifery Council (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (accessed 17 January 2022), sections 16.6 and 25.2

[44] General Medical Council (2012) Leadership and management for all doctors (accessed 17 January 2022)

32. If you are managing or leading a team, you should make sure that systems, including auditing and benchmarking, are in place to monitor, review and improve the quality of the team's work.

    a. You must work with others to collect and share information on patient experience and outcomes.

    b. You should make sure that teams you manage are appropriately trained in patient safety and supported to openly report adverse incidents.

    c. You should make sure that systems or processes are in place so that:

        i. lessons are learnt from analysing adverse incidents and near misses

        ii. lessons are shared with the healthcare team

        iii. concrete action follows on from learning

        iv. practice is changed where needed.

The organisational duty of candour

33. All health and care organisations have a duty to support staff to be open and honest with patients if something goes wrong with their care. Each of the four UK governments has considered ways to implement the organisational duty of candour, with some writing it into law (see appendix 2).

Appendix 1: Extracts from GMC and NMC standards and guidance that are referenced in this document

From Good medical practice

45. You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you must follow our guidance on *Openness and honesty when things go wrong: the professional duty of candour*, and you should:

a put matters right, if possible

b apologise (apologising does not, of itself, mean that you are admitting legal liability for what's happened)

c explain fully and promptly what has happened and the likely short-term and long-term effects

d report the incident in line with your organisation's policy so it can be reviewed or investigated as appropriate – and lessons can be learnt and patients protected from harm in the future.

73. To help keep patients safe you must:

a contribute to confidential inquiries

b contribute to adverse event recognition

c report adverse incidents involving medical devices (including software, diagnostic tests, and digital tools) that put the safety of a patient or another person at risk, or have the potential to do so

d contribute to incident reviews and/or investigations

e report suspected adverse drug reactions

f respond to requests from organisations monitoring public health.

When providing information for these purposes you must follow our guidance on *Confidentiality: good practice in handling patient information*.

76. If you have a formal leadership or management role, you must take active steps to create an environment in which people can talk about errors and concerns safely. This

includes making sure that any concerns raised with you are dealt with promptly and adequately, in line with your workplace policy and our more detailed guidance on *Raising and acting on concerns about patient safety*.

From Raising and acting on concerns about patient safety

13. Wherever possible, you should first raise your concern with your manager or an appropriate officer of the organisation you have a contract with or which employs you – such as the consultant in charge of the team, the clinical or medical director or a practice partner. If your concern is about a partner, it may be appropriate to raise it outside the practice – for example, with the medical director or clinical governance lead responsible for your organisation. If you are a medical professional in training, it may be appropriate to raise your concerns with a named person inyour training organisation

Medical professionals with extra responsibilities

21. If you are responsible for clinical governance or have wider management responsibilities in your organisation, you have a duty to help people report their concerns and to enable people to act on concerns that are raised with them.

22. If you have a management role or responsibility, you must make sure that:

a. there are systems and policies in place to allow concerns to be raised and for incidents, concerns and complaints to be investigated promptly and fully

b. you do not try to prevent employees or former employees raising concerns about patient safety – for example, you must not propose or condone contracts or agreements that seek to restrict or remove the contractor's freedom to disclose information relevant to their concerns

c. clinical staff understand their duty to be open and honest about incidents or complaints with both patients and managers

d. all other staff are encouraged to raise concerns they may have about the safety of patients, including any risks that may be posed by colleagues or teams

e. staff who raise a concern are protected from unfair criticism or action, including any detriment or dismissal.

Also see the raising concerns decision making tool.

From Leadership and management

24. Early identification of problems or issues with the performance of individuals, teams or services is essential to help protect patients.

All medical professionals

25. You must take part in regular reviews and audits of the standards and performance of any team you work in, taking steps to resolve any problems.

26. You should be familiar with, and use, the clinical governance and risk management structures and processes within the organisations you work for or to which you are contracted. You must also follow the procedure where you work for reporting adverse incidents and near misses. This is because routinely identifying adverse incidents or near misses at an early stage, can allow issues to be tackled, problems to be put right and lessons to be learnt.

27. You must follow the guidance in *Good medical practice* and *Raising and acting on concerns about patient safety* when you have reason to believe that systems, policies, procedures or colleagues are, or may be, placing patients at risk of harm.

Medical professionals with extra responsibilities

28. If you have a management role or responsibility, you must make sure that systems are in place to give early warning of any failure, or potential failure, in the clinical performance of individuals or teams. These should include systems for conducting audits and considering patient feedback. You must make sure that any such failure is dealt with quickly and effectively.

29. If you are managing or leading a team, you should make sure that systems, including auditing and benchmarking, are in place to monitor, review and improve the quality of the team's work. You must work with others to collect and share information on patient experience and outcomes. You must make sure that teams you manage are appropriately supported and developed and are clear about their objectives.

From: Decision making and consent

87. We use the term 'overall benefit' to describe the ethical basis on which decisions are made about treatment and care for adult patients who lack capacity to decide for themselves. This involves weighing up the risks of harm and potential benefits for the individual patient of each of the available options, including the option of taking no action. The concept of overall benefit is consistent with the legal requirements to consider whether treatment 'benefits' a patient (Scotland), or is in the patient's 'best interests' (England, Wales and Northern Ireland).

88. If you are the person with lead responsibility for the patient's treatment and care, before concluding that it is your responsibility to decide which option(s) would be of overall benefit to a patient who lacks capacity, you should take reasonable steps to find out:

a. whether there's evidence of the patient's previously expressed values and preferences that may be legally binding, such as an advance statement or decision

b. whether someone else has the legal authority to make the decision on the patient's behalf or has been appointed to represent them. *[or in Scotland if someone is applying to be granted such authority (see s49 Adults with Incapacity (Scotland) Act 2000)]

89. If there is no evidence of a legally binding advance refusal of treatment, and no one has legal authority to make this decision for them, if you are the person with lead responsibility for the patient's treatment and care, then you are responsible for deciding what would be of overall benefit to your patient.[5]

In doing this you must:

a. consult with those close to the patient and other members of the healthcare team, take account of their views about what the patient would want, and aim to reach agreement with them

b. consider which option aligns most closely with the patient's needs, preferences, values and priorities

c. consider which option would be the least restrictive of the patient's future options.

90. If a proposed option for treatment or care will restrict a patient's right to personal freedom, you must consider whether you need legal authorisation to proceed with it in the circumstances.

91. You should allow enough time, if possible, for discussions with those who have an interest in the patient's welfare, and you should aim to reach agreement about how to proceed.

From Treatment and care towards the end of life: good practice in decision making

84. Death and bereavement affect different people in different ways, and an individual's response will be influenced by factors such as their beliefs, culture, religion and values. You must show respect for and respond sensitively to the wishes and needs of the bereaved, taking into account what you know of the patient's wishes about what should happen after their death, including their views about sharing information. You should be

prepared to offer support and assistance to the bereaved, for example, by explaining where they can get information about, and help with, the administrative practicalities following a death; or by involving other members of the team, such as nursing, chaplaincy or bereavement care staff.

From The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

14. Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1. act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2. explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3. document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly.

16. Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1. raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

16.2. raise your concerns immediately if you are being asked to practise beyond your role, experience and training

16.3. tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

16.4. acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

16.5. not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

16.6. protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised.

For more information, please see Raising concerns: Guidance for nurses and midwives

From Future Nurse: Standards of proficiency for registered nurses (NMC, 2018)

Section 1.3: understand and apply the principles of courage, transparency and the professional duty of candour, recognising and reporting any situations, behaviours or errors that could result in poor care outcomes.

From Standards of proficiency for midwives (NMC, 2019)

Section 1.19 - understand and apply the principles of courage, integrity, transparency, and the professional duty of candour, recognising and reporting any situations, behaviours, or errors that could result in sub-standard care, dysfunctional attitudes and behaviour, ineffective team working, or adverse outcomes.

From Standards of proficiency for registered nursing associates (NMC, 2018)

Section 1.3 - understand the importance of courage and transparency and apply the Duty of Candour, recognising and reporting any situations, behaviours or errors that could result in poor care outcomes.

Appendix 2: The statutory duty of candour for care organisations across the UK

England

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 sets out a duty of candour. It requires all health and social care providers registered with the Care Quality Commission (CQC) to be open and transparent with people using services, and their families, in relation to their treatment and care. The regulation also sets out specific actions that providers must take when a 'notifiable safety incident' occurs. This includes informing people about the incident, providing reasonable support and providing truthful information and a timely apology. The CQC can prosecute for a breach of parts 20(2)a and 20(3) of this regulation.

The organisational duty of candour does not apply to individuals, but organisations providing health and care are expected to implement the duty throughout their organisation by making sure that staff understand the duty and are appropriately trained. The CQC provides guidance[45] for providers on meeting the duty of candour.

Northern Ireland

In April 2021 the Department of Health (Northern Ireland) launched a consultation on Duty of Candour Policy proposals and a 'Being Open Framework'.

The consultation outlined three policy proposals relating to a statutory duty of candour:

- A Statutory Individual Duty of Candour (IDC) with criminal sanctions, and a Statutory Organisational Duty with criminal sanctions;
- A Statutory IDC without criminal sanctions. Individuals would be sanctioned by their employer, regulator, and professional body, and a Statutory Organisational Duty with criminal sanctions; and
- A Statutory IDC without criminal sanctions, and separate criminal sanctions for withholding, destroying, or providing false or misleading information, and a Statutory Organisational Duty with criminal sanctions.

[45] Care Quality Commission (2021) The duty of candour: guidance for providers (accessed 17 January 2022)

The consultation followed recommendations for a statutory duty of candour made by the Inquiry into Hyponatraemia-Related Deaths, which reported in January 2018. This examined the circumstances relating to the deaths of five children in Northern Ireland hospitals.

Scotland

The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 and The Duty of Candour Procedure (Scotland) Regulations 2018 set out an organisational duty of candour on health, care and social work services in Scotland. The duty came into effect on 1 April 2018.The overall purpose of the duty is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended incident resulting in harm or death, as defined by the Act.

Organisations are required to follow a duty of candour procedure which includes notifying the person affected, apologising and offering a meeting to give an account of what happened.

The duty also requires the organisation to review each incident and consider the support available to those affected (this includes both those who deliver and receive care and support services).

Organisations are also required to publish an annual report on when the duty has been applied. This includes the number of incidents, how the organisation has implemented the duty and what learning and improvements have been put in place.

Alongside the legal requirements set by the Act, the Scottish Government has also published guidance[46] on the implementation of duty of candour for all organisations that provide health services, care services or social work services in Scotland.

Wales

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 place a number of duties on responsible bodies providing NHS care. This includes a duty to be open when harm may have occurred:

'where a concern is notified by a member of the staff of the responsible body, the responsible body must, where its initial investigation determines that there has been moderate or severe harm or death, advise the patient to whom the concern relates, or his or her representative, of

[46] Scottish Government (2018) Organisational duty of candour: guidance (accessed 17 January 2022)

the notification of the concern and involve the patient, or his or her representative, in the investigation of the concern'.

The Welsh Government's Health and Care Standards Framework, includes a standard called 'listening and learning from feedback'. In meeting this standard, the framework advises that 'health services are open and honest with people when something goes wrong with their care and treatment'. The standards provide a framework for how services are organised, managed and delivered on a day-to-day basis.

On 1 June 2020, The Health and Social Care (Quality and Engagement) (Wales) Act 2000 became law and came into force on 1 April 2023 The Welsh government also issued The Duty of Candour Statutory Guidance 2023 on 1 April 2023 to support the implementation of the duty of candour.

The Act established an organisational duty of candour on providers of NHS services, requiring them to be open and honest with patients and service users when things go wrong.

The legislation places a duty of candour on providers of NHS services (NHS bodies and primary care). The duty requires NHS providers to follow a process – to be set out in Regulations – when a service user suffers an adverse outcome which has or could result in unexpected or unintended harm that is more than minimal and the provision of health care was or may have been a factor.

The Act also requires NHS providers to report annually about when the duty has come into effect.

The Welsh government also issued The Duty of Candour Statutory Guidance 2023 on 1 April 2023 to support the implementation of the duty of candour.

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You are welcome to contact us in Welsh. We will respond in Welsh, without this causing additional delay.

Mae croeso i chi gysylltu â ni yn Gymraeg. Byddwn yn ymateb yn Gymraeg, heb i hyn achosi oedi ychwanegol.

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