Where do we publish information released under the Duty of Candour?

Please go to the 'Your feedback matters' section on our website at **www.dpt.nhs.uk** to view information released under the Duty of Candour.

We also publish feedback from people who use our services, their carers and family members, about the quality, safety and effectiveness of our services. All reported safety incidents and the feedback we publish is anonymous.

Where can I find out more about the Duty of Candour?

For specific enquiries, please contact our Patient Advice and Liaison Service (PALS) on the number opposite.

Your feedback

If you would like to know more about us, need information in a different language or format or have a concern, compliment or complaint, then please contact our PALS Team:

PALS Team
Devon Partnership NHS Trust
Wonford House, Dryden Road
Exeter EX2 5AF

Freephone: 0800 0730741
Email: dpn-tr.pals@nhs.net

You will also find useful information about our services and issues related to mental health and wellbeing on our website.

www.dpt.nhs.uk

Devon Partnership NHS
NHS Trust

Duty of Candour

Being open, honest and transparent

www.dpt.nhs.uk

What is the Duty of Candour?

The Duty of Candour comes from a recommendation in the Francis Inquiry report, published in February 2013, which looked at why there was poor care at Mid Staffordshire NHS Foundation Trust between 2005-2009. The report said that the main reason was because the Trust Board did not listen to either patients or staff and they did not put right what they were told was wrong.

What is the aim of the Duty of Candour?

The aim of the Duty of Candour is to make sure that we are open and transparent when things go wrong and cause harm to people we are looking after. Occasionally things do go wrong, but only a small number of these incidents cause actual harm.

We want people who use our services to be able to raise concerns freely and to ask questions about their care and our services. We will publish information about how our services are working, including information on where we could be doing better.

Reference: 418/12/16

When did the Duty of Candour come into force?

The Duty of Candour came into force in November 2014. The Care Quality Commission (CQC), which is the regulator for all health and social care services in England, will make sure that we follow the Duty of Candour process. Our Trust will be given a fine if we do not meet the requirements of the Duty of Candour.

Does the Duty of Candour apply every time something goes wrong?

The Duty of Candour does not apply to every incident, only those meeting any of the three criteria listed below. It is not necessary for a complaint to have been made to us before the Duty of Candour process is followed.

Severe harm

Where the incident causes death, permanent lessening of bodily, sensory motor, psychological or intellectual function, including the removal of the wrong limb or organ or brain damage that is related directly to the incident and not the underlying illness or condition.

Moderate harm

Where the incident causes an unplanned return to surgery, an unplanned readmission, 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).

Prolonged psychological harm

When a person has experienced, or is expected to experience, psychological harm for a continuous period of at least 28 days.

What is the process for fulfilling the Duty of Candour?

Following an incident which meets one of these criteria, we must:

1. Tell you as soon as possible (but in any event within ten days) after becoming aware that something may have gone wrong. If you are under 16, if you lack mental capacity or if the incident causes a death, we will speak to your next of kin
2. Provide support to you in relation to the incident, including when notifying you
3. Advise you of any further enquiries that may need to be made
4. Offer you an apology which will be followed up in writing and will include everything we know about what went wrong and our plans to make changes so that a similar incident does not happen again.