



Introduction

Prior to the introduction of the duty of candour there was no legal duty upon healthcare providers to share information with patients and/or their families in the event of an incident of injury or harm. The duty of candour was introduced in 2014 in response to the concerns raised through the inquiry conducted by Sir Robert Francis into Mid Staffordshire NHS Foundation Trust which uncovered poor patient care and more importantly found evidence that patients were sometimes not given a full and frank explanation by the NHS Trust when things had gone wrong. The Francis Inquiry report was published on 6 February 2013 and recommended that there should be more openness with those receiving care and therefore raised the question of a 'duty of candour', requiring all NHS staff to be transparent about mistakes.

As a result of the Francis Report, the statutory duty of candour was introduced and professional organisations such as the General Dental Council produced standards around transparency in dealing with patients referred to as the professional duty of candour. The duty now plays a crucial role in the maintenance of a safe, open and transparent culture in the healthcare environment.

There are two aspects to the duty of candour, (i) a statutory duty of candour and (ii) a professional duty of candour. Both categories incorporate the concept of openness and transparency and both aspects will be examined in this advice sheet.

What is the statutory Duty of Candour?

The statutory duty of candour was introduced in England in November 2014 for NHS bodies such as NHS Trusts. It was extended in April 2015 to cover all other care providers registered with the Care Quality Commission ("CQC") to include dental practices.

As per regulation 20 of the Health and Social Care Act 2008, Regulations 2014 ("the Regulations"), dental practices and independent dental providers registered with the CQC all have a statutory duty of candour which is enforceable by law and regulated by the CQC.

What incidents are covered by the statutory duty of candour?

Regulation 20 introduces the concept of a "notifiable safety incident" and where there is a notifiable safety incident the statutory duty of candour applies.

A "notifiable safety incident" has a different definition depending on whether the provider is a dental practice or a body such as an NHS Trust. Our members will have a different duty if they are practicing at an NHS Trust e.g. as a Consultant Orthodontist or in primary care, for example working as a specialist orthodontist in a practice. Notifiable Safety incident for health service bodies such as NHS Trusts

For an NHS Trust a notifiable safety incident means any unintended or unexpected incident that occurred in respect of a patient which in the reasonable opinion of a health care professional could or has resulted in (i) the death of the patient directly related to the incident

(ii) severe harm, moderate harm or prolonged psychological harm to the patient.

“Severe harm” means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions including the removal of a wrong limb or organ or brain damage related to the incident.

“Moderate harm” means harm that requires a moderate increase in treatment and significant but not permanent harm. A “moderate increase in treatment” is said to mean an unplanned return to surgery, an unplanned re-admission or a prolonged episode of care, extra time in hospital or as an outpatient, including the cancelling of treatment or transfer to another treatment area such as I.T.U.

Notifiable Safety incident for dental practices and other Care Quality Commission staff

For a dental practice (“other registered person”) a notifiable safety incident means any unintended or unexpected incident that occurred in respect of a patient that in the reasonable opinion of the health care professional appears to have resulted in (i) the death of the patient where the death relates directly to the incident (ii) an impairment of the sensory, motor or intellectual functions of the patient which has lasted/is likely to last a continuous period of 28 days (iii) changes to the structure of the patient’s body (iv) the patient experiencing prolonged pain or prolonged psychological harm or (v) the shortening of the life expectancy of the patient or (vi) the patient requires treatment by the health professional to prevent death or injury to the patient.

What sorts of incidents can arise in dentistry that attract the duty of candour?

(i) the death of a patient. Although rare, there have been instances where patients have died during routine dental surgery. For example, in 2020 when a fifteen-year old girl died at GOSH following a GA for simple orthodontic extractions. A further example was in July 2017 when a patient taking warfarin, suffered a fatal haemorrhage following multiple dental extractions.

- (ii) the removal of a wrong adult tooth
- (iii) the discovery of a retained root that had been missed by the dentist
- (iv) damage to the lingual nerve resulting from a wisdom tooth extraction
- (v) poor root canal treatment resulting in teeth needing to be extracted
- (vi) the discovery that an implant fixture did not have a sufficient level of bone support which resulted in failure

The CQC provides some helpful examples of situations where it considers that the duty of candour would be triggered in a dental context such as an overdose of midazolam as a sedation agent and severe hypochlorite extravasation during endodontic treatment.

What does the statutory duty of candour require a dental practitioner to do if there is a notifiable incident?

As soon as possible after becoming aware that a notifiable safety incident has occurred, you must arrange for one or more of your representatives to provide, in person, to the relevant person (e.g. patient, parent or family member) the following:

- a. Information that the incident has occurred;
- b. provide reasonable support to the relevant person in relation to the incident, including when giving the notification. In its guidance on the duty of candour, the CQC suggest that this could mean 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 and/or the support of an advocate;
- c. provide an account, (which to the best of your knowledge is true), of all the facts you know about the incident as at the date of the notification;
- d. advise the relevant person what further enquiries into the incident the health service body believes are appropriate;
- e. include an apology; and
- f. ensure that a record of the notification is made in a written record which is kept securely

The above information must be followed up with a written notification and copies of all correspondence with the relevant patient must be retained and information regarding any further enquiries into the incident. It should be noted that the Regulations placed a requirement on you to act as soon as reasonably practicable.

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Can an apology be avoided under the statutory duty of candour if there is a concern about litigation?

No. A key aspect of the duty of candour is the idea of an apology. The CQC's guidance highlights that this apology does not constitute as a form of admission of fault or liability. In order to fulfill the duty of candour an apology must be given for the harm caused, regardless of fault, as well as being clear and open about what has happened.

What happens where multiple providers are likely to be responsible?

According to the CQC's guidance where multiple providers contributed to the harm, they should liaise and work together in the investigation that follows as they would for any other incident. Each provider still has its own responsibilities under the duty of candour. They must assure themselves that they have met them.

What happens if there is a breach of the duty of candour?

A breach of the statutory duty of candour may result in the issuing of fixed penalty notices and prosecution by the CQC. Non-compliance may have an impact on a provider's continued registration with the CQC.

Does the duty of candour apply in Wales, Scotland and Northern Ireland?

The statutory duty of candour in Scottish law is governed by the Health (Tobacco, Nicotine and Care etc.) (Scotland) Act 2016 and the Duty of Candour Procedure (Scotland) Regulations 2018. It came into effect on 1 April 2018.

In Wales, a statutory duty of candour is set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 which is due to come into force in spring 2023

There is no statutory duty of candour in Northern Ireland as yet. Between 12 April 2021 and 31 August 2021, the Department of Health consulted on policy proposals to enact a statutory Duty of Candour in Northern Ireland.

What is the professional duty of candour for dentists?

The General Dental Council ("GDC") has issued guidance to dental professionals on the duty of candour setting out what the GDC expects dentists and dental care professionals to do when something goes wrong with a patient's treatment. The guidance is called "Being open and honest with patients when something goes wrong [The professional duty of candour]"

The GDC states that the professional duty of candour is all about being open and honest with patients (or their family, carer or advocate) and should be considered in conjunction with the duty to upon every GDC registrant to raise concerns you may have about patient safety under principle 8 of the GDC Standards ('Raise concerns if patients are at risk').

What does the GDC require its registrants to do?

The GDC requires all dental professionals to be honest with patients from the outset before treatment starts and have an open discussion with patients/obtain consent. When things go wrong with a patient's care, the GDC requires that you must:

- tell the patient;
- apologise;
- offer an appropriate remedy or support to put matters right (if possible); and
- explain fully the short and long term effects of what has happened.

How should the patient be told?

The GDC guidance states that as soon as you realise that something has gone wrong with a patient's care which has caused them harm or distress, or which could do so in the future, you must tell them clearly, in a way that they can understand. Most patients will want to know what has happened, what has been done or can be done to put matters right and what it means for them. You should answer any questions fully and honestly. If the patient makes clear that they do not want to know the details, you should respect their decision. However, you should let them know that they can have further information later if they change their mind. You should record your discussion with the patient (including their decision not to have further information, if applicable) in their notes.

How should a dental professional go about apologising?

The GDC states that you should make the apology personal to the patient and relevant to their circumstances rather than a general wide-ranging statement.

The GDC guidance sets out that you should explain:

- what happened;
- what has been done or can be done to put matters right; and
- what will be done to stop the same thing happening to someone else (if relevant).

Who should make the apology?

The GDC guidance sets out that the most appropriate team member should make the apology and give the explanation to the patient. When apologising to the patient and explaining

what happened, you do not have to take responsibility for something that went wrong which was not your fault (such as a mistake by another member of the team). Make sure that the patient knows who to contact if they have further questions.

The GDC's view is that you may need to follow up a verbal apology with a written one. However, it is important to note that if the incident is of sufficient seriousness to meet the requirements of the statutory duty (see above), a written apology must be given. The apology must be recorded in the patient's notes.

What about staff training on the duty of candour?

Dental practices are required to ensure staff understand the need to be open and honest with patients and that the culture of the practice or workplace supports this. The GDC recommends training for the whole team in communication skills, including handling complaints. Importantly, dental professionals must not prevent or try to discourage staff from being open and honest with patients when something goes wrong.

What if both the statutory and professional duty of candour applies?

The dental professional must follow the procedure set out in the statutory duty of candour which will ensure compliance with the professional duty. However, even if the very specific circumstances of the statutory duty does not apply, for example because the levels of harm are not as serious as those set out in the statutory duty, you should abide by the GDC guidance in the Professional Duty of Candour. Whatever incident or mistake, the patient should be told and the professional duty of candour will apply.

What could happen to a dental professional who breaches the GDC's guidance on the Professional Duty of Candour?

There could be a fitness to practise enquiry and a hearing which could depending on the circumstances, lead to a dental professional losing their registration.

A breach in relation to the duty of candour is likely to be a breach of the GDC's Standards for the Dental Team which require dentists and dental care professionals to:

- Put patients' interests first (principle one);
- Be honest and act with integrity (standard 1.3); and
- Offer an apology and a practical solution if a patient makes a complaint (standard 5.3.8).

The GDC's guidance points out that candour means being open and honest with all patients, whether they have made a complaint or not.

References

Care Quality Commission - Updated guidance on meeting the duty of candour – May 2022

The General Duty Council Guidance "Being open and honest with patients when something goes wrong" 1 July 2016

Updated and reviewed by the Clinical Governance Directorate of the British Orthodontic Society October 2022. Recommendations may change in the light of new evidence.

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