Central Bedfordshire

Duty of Candour Policy

Adult Social Care

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Duty of Candour Policy

Directorate:	Adult Social Care and Housing		
Division & Service:	Adult Social Care		
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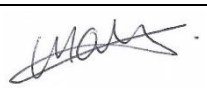
Policy Owner Signatories

Name	Title/Role	Signature	Organisation	Date
Stuart Mitchelmore	Service Director, Adult Social Care		Central Bedfordshire Council	25/09/2025
Laura Oxley	Head of Community Assessment		Central Bedfordshire Council	05/09/2025
Amy Thulbourne	Head of Care, Support and Quality Improvement		Central Bedfordshire Council	05/09/2025

CQC Assurance Key Areas:

This policy document supports CQC Assurance Key Areas (detailed in section 6):

Safe	Effective	Caring	Responsive	Well-led
●	●	●	●	●

This document is not controlled when printed.

It is the responsibility of every individual to ensure that they are working to the most current version of this document.

Contents

1. Introduction

1.1. Central Bedfordshire Council promotes a culture of openness, transparency, and effective communication with people using services, their families, and carers. This is vital for delivering high-quality, person-centred care that safeguards wellbeing and autonomy.

1.2. The Duty of Candour requires all registered providers and staff in adult social care to be honest and open when things go wrong, whatever the cause. Practitioners must acknowledge and address mistakes or harm promptly, share relevant information, apologise where appropriate, take action to put matters right, and keep accurate records in line with their professional standards.

1.3. The statutory Duty of Candour was introduced under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It applies to all Care Quality Commission (CQC)-registered services and remains a regulatory priority.

2. Purpose

2.1. This policy outlines how the Central Bedfordshire Council Adult Social Care services will:

- Embed a culture of openness and transparency.
- Clearly define notifiable safety incidents and related harm thresholds.
- Ensure prompt and honest communication with people accessing services or their representatives.
- Set out required actions following such incidents, including providing support, offering an apology, and sharing accurate information.

3. Scope

3.1. This policy applies to:

- all services provided directly by Central Bedfordshire Council's Adult Social Care
- all permanent and temporary staff, volunteers, and contracted care providers

3.2. It applies to both regulated and non-regulated activities where the wellbeing or safety of people accessing services is affected.

3.3. Regulated services include:

- care homes
- reablement services
- step up/step down services

3.4. Services that are not regulated but are required to follow this policy include:

- day opportunities
- employment services
- supported living

3.5. This includes social care practitioners: Community Assessment Officers, Care workers, AMHPs and Occupational Therapists working in Adult Social Care, whether employed directly, through locum arrangements, or via contracted services.

4. Legal and Regulatory Framework

4.1. This policy has been reviewed with reference to the following key pieces of legislation and guidance:

- Care Act 2014
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulation 20 – Duty of Candour)
- CQC Fundamental Standards of Care
- The Francis Report (Mid Staffordshire Inquiry)
- Working Together to Safeguard Adults (updated multi-agency guidance)

Professional Standards:

- Social Workers: Social Work England Professional Standards, BASW Code of Ethics
- Occupational Therapists: HCPC Standards of Conduct, Performance and Ethics
- Nurses and Midwives: Nursing and Midwifery Council (NMC) Code
- Care Workers / Support Staff: Skills for Care Code of Conduct, Care Certificate Standards

5. Definitions

Term	Definition
Apology	A sincere expression of regret. It is not an admission of legal liability.
Candour	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)
Notifiable Safety Incident	An unintended or unexpected incident that occurred during the provision of a service, resulting in or having potential to result in: death; significant harm; or prolonged psychological, physical, or emotional distress.
Openness	Creating a safe environment where staff and people accessing services feel confident to raise concerns without fear of reprisal.
Reasonable Support	'Reasonable Support' will vary with every situation, but could include, for example: • environmental adjustments for someone who has a physical disability • an interpreter for someone who does not speak English well • information in accessible formats

	• signposting to mental health services • the support of an advocate • drawing their attention to other sources of independent help and advice such as AvMA (Action against Medical Accidents) or Cruse Bereavement Care.
Relevant Person	The person, or a person lawfully acting on their behalf (e.g., legal guardian, person with lasting power of attorney).
Transparency	Sharing accurate information regarding outcomes with stakeholders and regulators

6. Principles of the policy

6.1. The Duty of Candour will be applied where there is an unintended or unexpected incident that occurs in respect of a person during the provision of a regulated or non-regulated activity where:

A. it appears to have resulted in:

- the death of the person accessing service, where the death relates directly to the incident rather than to the natural course of the person's illness or underlying condition,
- an impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days,
- changes to the structure of the person's body,
- the person experiencing prolonged pain or prolonged psychological harm, or
- the shortening of the life expectancy of the person; or

B. requires treatment by a health care professional in order to prevent—

- the death of the person accessing services, or
- any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.

7. Duty of Candour process

7.1. All staff must immediately report any incident they believe could be a notifiable safety incident to the Registered Manager or Service Manager.

7.2. When a report is received, the Manager (or nominated deputy) must decide whether a notifiable safety incident **has occurred or is likely to have occurred**. They must act quickly and appropriately in line with

- **Duty of Candour requirements**, and **Central Bedfordshire Council's incident reporting** procedures.
- They must also notify the **Head of Service** and/or **Service Director**, if required.

7.3. The following steps must be followed when responding to a notifiable safety incident:

Step 1: Recognise and assess the incident

- Confirm whether the incident involves a "relevant person" (usually the person receiving Adult Social Care services, or their representative).
- Assess whether the incident has resulted in — or could result in — moderate harm, severe harm, or death, meeting the threshold for a notifiable safety incident.

If the incident meets the threshold, escalate and report:

- Record the incident on the organisation's formal reporting system (**AssessNET**).
- Inform the Senior Management Team, and where appropriate, notify relevant regulatory bodies (e.g. CQC or local commissioners).
- The **Senior Management Team** will decide who is best placed to communicate with the person (or their representative) going forward.

Step 2: Be open and transparent with the relevant person

- The nominate officer will communicate with the relevant person as soon as reasonably practicable after becoming aware of the incident.
- Ensure the discussion is honest, clear, and respectful, even if all facts are not yet known.

Step 3: Provide a factual explanation

- Share the facts that are known at the time of communication.
- Avoid speculation and clearly explain what steps are being taken to investigate further.

Step 4: Offer a sincere apology and appropriate support

- Offer a meaningful apology, acknowledging the incident and any harm caused.
- Provide appropriate practical or emotional support, such as reassurance, access to additional services, or signposting to advocacy resources.

Step 5: Document the communication

- Accurately record all discussions with the relevant person in the service's records.
- Provide the individual with a written summary of the conversation and any actions or next steps agreed upon.
- Example letter templates are provided in appendix 1

Step 6: Provide updates as further information becomes available

- Keep the relevant person updated with any new information, including the outcomes of investigations or changes to their care.
- Ensure all updates are timely, clear, and documented.

Required Actions and Timeframes

Stage	Required Action	Expected Timeframe
1. **Initial Verbal Notification**	• Notify the relevant person or their representative • Offer a factual explanation of what is known • Provide a sincere apology • Outline planned actions and next steps	Within **10 working days** of identifying the notifiable safety incident
2. **Written Notification**	• Provide a written summary of the initial conversation • Include key details: what occurred, the apology, steps being taken, and contact information	Within **10 working days** of the verbal notification
3. **Ongoing Communication**	• Keep the relevant person updated as the investigation progresses • Provide any new or significant information	At least every **20 working days**, or sooner if appropriate
4. **Final Outcome / Closure**	• Share the outcome of the investigation • Explain findings, any actions taken or changes made, and offer a final apology	Ideally within **6 - 8 weeks**, or as soon as practicable following investigation completion

Information and guidance relating to reporting and investigating incidents is available: Accident, incident, near miss reporting and investigation

8. Monitoring and Reporting Arrangements

8.1. Incidents must be logged in AssessNET, clearly indicating if Duty of Candour applies. Registered managers will report all incidents and accidents to the Head of Service.

8.2. This information will be presented bi-monthly to the Performance Management Board and the Adult Social Care balanced scorecard will include a scorecard on the number of Duty of Candour incidents and the outcomes of the subsequent investigations.

8.3. The Practice Governance Board will oversee issues and emerging trends and ensure that learning is shared across services to prevent recurrence.

9. Roles and Responsibilities

9.1. Director of Adult Social Care & Housing: Responsible for delegating the management and response to Duty of Candour incidents, and accountable for ensuring compliance with all relevant regulatory obligations.

9.2. Head of Service (Adult Social Care): Responsible for ensuring the implementation of actions and the reporting of relevant incidents within their respective service areas to the Service Director, the Performance Board, and the Director.

9.3. Operational and Registered Managers: Must escalate notifiable incidents and make sure policies are followed. They are also responsible for helping their staff understand and comply with the Duty of Candour.

9.4. All Employees: Understand and act within the Duty of Candour framework. They must also comply with the codes of practice and ethical frameworks relevant to their profession.

9.5. Managers are responsible for embedding learning from incidents into supervision and team discussions, ensuring that lessons are understood and applied in future practice.

9.6. Managers will monitor the implementation of the policy to identify any further training need.

10. Assurance Key Areas

10.1. This policy supports the Care Quality Commission (CQC) Assurance Key Areas below:

Key question:	**Statements**
Safe	• Proactive action is taken to prevent and manage risks to people's safety. • People are supported to understand and manage risks, balancing safety with autonomy. • Learning from safety incidents is embedded to drive continuous improvement.
Effective	• Outcomes for people are assessed and monitored to ensure high-quality care and support. • When things go wrong, learning is captured and used to improve practice, with Duty of Candour applied transparently.
Caring	• Communication is open, respectful, and compassionate when people experience harm. • Empathy is demonstrated in challenging situations, ensuring people are informed and supported throughout
Responsive	• Concerns and incidents are addressed promptly, with active listening and appropriate action. • People are provided with information, advocacy, and reassurance when things go wrong.
Well-led	• A culture of openness, honesty, and continuous learning is embedded throughout the organisation. • Leadership ensures staff understand and apply Duty of Candour confidently and consistently. • Governance systems support accountability and the sharing of learning from incidents.

11. Relevant Policy and Guidance

- Corporate Incident Investigation and Reporting: Guidance
- Corporate Health and Safety Policy
- Need to Know Guidelines

12. Evaluation and Review

12.1. This policy will be reviewed every 2 years, or sooner in response to:

- Changes in legislation or CQC guidance.
- Significant incidents or learning from practice

13. Appendices

- **Appendix 1:** Duty of Candour Initial Letter – Standard (Letter 1a)
- **Appendix 2:** Duty of Candour Initial Letter – Serious Incident (Letter 1b)
- **Appendix 3:** Duty of Candour Investigation Outcome Letter (Letter 2)

Appendix 1 – Duty of Candour Initial Letter template – Standard (Letter 1a) to be sent from any manager – no CQC involvement (download letter 1a template here)

Dear [Name]

Subject heading 12pt Calibri bold

I'm writing to share my sincere regret that **[you/your relative]** has/have been involved in an incident whereby **[briefly describe event]**. I appreciate how upsetting this may have been for you, and I want to apologise for the distress this has caused.

We are committed to being open and honest when things do not go as planned, and to ensuring that people who use our services and their families receive clear and truthful information. *Adult social care providers, like NHS organisations, have a legal duty of candour when things go wrong* ***– [dependent on service area].***

Our immediate concern is always **[your/your relative's]** safety and wellbeing, and we will ensure that any care or support needs are addressed and maintained. **[Name of Service Manager/nominated officer]** will be in touch with you personally to talk through what has happened, answer any questions you may have, and explain the steps we are taking to look into the incident.

As part of this process, the incident will be fully investigated by senior staff and our Quality and Improvement team. Their role is to find out what happened, identify any lessons to be learned, ensure improvements are made, and reduce the chance of similar situations happening in the future across our services.

Once the investigation is complete, we would very much like to share our findings with you and hear any further thoughts or questions you may have. This can be done by phone or in person, whichever feels most comfortable for you, and we will arrange this entirely at your convenience. Please don't feel under any pressure to take part — the invitation is there if you wish.

The investigation can take up to 8 weeks to complete. During this time, **[Senior Manager / Nominated Officer (same as above)**] will remain your main contact and is available by telephone or email at any point should you want to get in touch: [insert details].

Once again, I am truly sorry for the upset this has caused. Please be reassured that we are committed to learning from this incident and sharing those lessons with our teams, so we can continue to improve the care and support we provide.

If you would like to talk further, please don't hesitate to contact me directly using the details below, or reach out to **[Senior Manager / Nominated Officer].**

Yours sincerely

A.N. Other
Job title
Direct telephone 0300 300 XXXX
Email forename.surname@centralbedfordshire.gov.uk
Please reply to: (optional)
Address

Appendix 2 – Duty of Candour Serious Incident Letter template – (Letter 1b) to be sent from Head of Service or above – CQC involvement (download letter 1b template here)

Dear **[Name]**

Subject heading 12pt Calibri bold

I'm writing to share my sincere regret that **[you/your relative]** has/have been involved in an incident whereby **[briefly describe event].** I understand how upsetting this may have been for you, and I want to apologise for the distress this has caused.

We always strive to provide safe, high-quality care, but sometimes things do not go as planned. When this happens, we believe it is important to be open and honest, and to make sure that people who use our services and their families are kept fully informed. Adult social care providers, like NHS organisations, also have a legal duty of candour when something goes wrong – [dependent on service area].

Investigation and Next Steps
Our immediate concern is always **[your/your relative's**] safety and wellbeing, and we will ensure that any care or support needs are addressed and maintained.

I will be in touch with you personally to talk through what has happened, answer any questions you may have, and explain the steps we are taking. I will stay in regular contact with you as the investigation progresses and will remain your main point of contact throughout.

The incident will be investigated in detail by senior staff and our Quality and Improvement team. Their role is to understand what happened and why, identify any lessons, and make the changes needed to reduce the likelihood of something similar happening again. The incident has also been reported to the Care Quality Commission (CQC), who ensure our processes are followed properly and that any learning is shared across our services.

Your Involvement
We value the input of people who use our services and their families. Once the investigation is complete, I would like the opportunity to share our findings and recommendations with you, and to answer any further questions you may have.

This discussion can take place either face-to-face or by telephone, depending on what feels most convenient for you. Please don't feel under any pressure to take part — it is simply an opportunity if you wish and will be arranged at a time that suits you.

The investigation may take up to 8 weeks to complete / At this stage, I cannot provide an exact timescale [insert additional context if needed], but I will stay in regular contact with you and keep you updated on any developments. I would also be grateful if you could let me know how you or your relative would like to be referred to in our report.

Please don't hesitate to contact me directly if you have any questions or concerns in the meantime.

Once again, I want to offer my heartfelt apologies for any distress this incident has caused. Please be reassured that we are committed to learning from what has happened and using those lessons to improve the safety and quality of the care we provide.

Yours sincerely

A.N. Other
Head of Service or above

Direct telephone 0300 300 XXXX
Email forename.surname@centralbedfordshire.gov.uk

Please reply to: (optional)
Address 1

Appendix 3 – Duty of Candour Investigation Outcome Letter (Letter 2) (download letter 2 template here)

Dear **[Name]**

Subject heading 12pt Calibri bold

Following my previous letter dated **[insert date]** regarding **[incident description],** I am writing to provide an update now that our investigation has concluded.

We understand that this incident may have caused distress, and I want to offer my sincere apologies once again. We are committed to being open and transparent whenever things do not go as planned, and to keeping you fully informed throughout the process.

During the investigation, we liaised with [insert relevant teams/external organisations as required] to ensure a thorough review of the circumstances.

Key Findings and Actions
The main findings and any improvements we are making are summarised below:

- [Insert key points/outcomes]
- [Insert any identified changes to practice or service improvements]

A copy of the final report is enclosed. As stated in our earlier letters, we would very much like the opportunity to discuss our findings with you and answer any questions. This can be arranged either face-to-face or over the phone, at a time convenient for you, with no obligation to meet if you prefer not to.

Please accept my sincere apologies for any distress this incident may have caused. If you have any questions or concerns, please do not hesitate to get in touch.

Yours sincerely

A.N. Other
Head of Service or above

Direct telephone 0300 300 XXXX
Email forename.surname@centralbedfordshire.gov.uk

Please reply to: (optional)
Address 1