

Midwives' duty of candour

A key recommendation of the Francis report (2013) arising from the Mid Staffordshire NHS Foundation Trust Inquiry was to establish a culture of openness in all health services, including midwifery, through a duty of candour. Midwifery services regulated by the Care Quality Commission (CQC) are now subject to a statutory duty of candour under revised fundamental standards for quality and safety, which came into force on 1 April 2015 (Nursing and Midwifery Council (NMC), 2015).

The duty of candour is aimed at encouraging transparency in health services in an attempt to prevent a repeat of the deliberate concealment of poor care and negligence found in the Mid Staffordshire Hospital scandal (Department of Health (DH), 2014).

The Francis report (2013) defines candour as the volunteering of relevant information to persons who have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint has been made. The duty places a legal obligation on midwives to report poor practice where women or their babies have been harmed.

Midwives are subject to two forms of duty requiring candour. An organisational duty that is imposed on the midwifery service and a professional duty imposed by the NMC (2015). It is essential that midwives discharge their duties of candour or face sanctions from their employer and professional regulator.

Statutory organisational duty of candour

The organisational duty of candour is imposed under the provisions of the Health and Social Care Act (2008) and the Health and Social Care Act (2008) (Regulated Activities) Regulations (2014). It applies to all health service bodies regulated by the CQC, the statutory regulator for adult

health services in England. Midwifery services in hospitals and the community are subject to these regulations.

The 2014 regulations introduced revised fundamental standards for health bodies registered with the CQC and include an organisational duty of candour. The Health and Social Care Act (2008) (Regulated Activities) Regulations (2014), regulation 20 requires midwifery services to act in an open and transparent way with women in relation to their midwifery care and treatment. It imposes a general duty to be candid with women whether or not there has been a complaint and seeks to encourage an open, honest culture in all maternity services.

In practice, the organisational duty of candour requires a midwife to tell the woman or their representative about a notifiable safety incident as soon as is reasonably practicable after the incident.

Notifiable safety incident

A notifiable safety incident is defined as one where a woman suffered or could suffer unintended harm resulting in:

- Death
- Severe harm
- Moderate harm
- Prolonged psychological harm.

The definition of these terms is derived from the National Patient Safety Agency's *Seven Steps to Patient Safety* (2004). This defines harm as:

- Injury
- Suffering
- Disability
- Death.

A prolonged psychological harm is one that must be experienced continuously for 28 days or more.

To meet the threshold for disclosure under the duty of candour, the harm must be moderate or severe (National Patient Safety Agency, 2004).

- No harm:
 - Impact prevented—any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm.
 - Impact not prevented—any patient

safety incident that ran to completion but no harm occurred to people receiving care.

- Low harm: any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving care
- Moderate harm: any patient safety incident that resulted in a moderate increase in treatment and which caused significant, but not permanent harm, to one or more persons receiving care
- Severe harm: any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving care
- Death: any patient safety incident that directly resulted in the catastrophic death of one or more persons receiving care.

Duty to give an explanation and apology

Once a notifiable safety incident has arisen with a woman, the midwifery service must give that woman a full explanation of what is currently known and details of any further enquiry to be carried out. The woman must also be given an apology. Both the explanation and apology must be made in person. The duty to explain and apologise includes a requirement to support the woman during this process and could include the provision of an interpreter to ensure the woman understands the explanation and is able to ask questions of the midwife. It also includes the need to give emotional support to the woman.

Once an explanation and apology has been given, the midwifery service is required to provide the woman with a written note of the discussion and must ensure that a written notice of the incident and copies of correspondence are kept.

Professional duty of candour

In its response to the Francis report (2013), the Government made clear that a statutory organisational duty of candour alone was not enough to promote openness and honesty. In the Government's view, it was critical to ensure that professionals also had an individual duty of candour imposed on

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them (DH, 2014).

Imposing a professional duty of candour on all registered health professionals, including midwives, ensures a consistent approach to candour and the reporting of errors. A professional duty also ensures that those who seek to obstruct others in raising concerns will be in breach of their professional code and guilty of professional misconduct.

The Professional Standards Authority (PSA) oversees the regulation of health and social care professionals by regulating the professional regulators, including the NMC. The PSA were charged by the government to ensure clear and consistent guidance and standards to the duty of candour by the professional regulators. The NMC is currently one of only two health and social care regulators to have explicit standards requiring their registrants to be open and candid with patients.

The NMC (2015) issued a new code of standards for nurses and midwives on 31 March 2015. The standards include a specific standard on a professional duty of candour. Standard 14 of the *Code* (2015) requires midwives to:

- 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.

The professional duty of candour imposed on midwives by the NMC reflects the joint statement on the professional duty of candour issued by the nine health and social care regulators (General Medical Council (GMC), 2014).

The jointly agreed statement requires that: every health professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress.

It means that midwives have a professional obligation to:

- Tell the woman or, where appropriate, the woman's advocate, carer or family when something has gone wrong
- Apologise to the woman
- Offer an appropriate remedy or support to put matters right if possible and
- Explain fully to the woman the short- and long-term effects of what has happened.

Midwives must also be open and honest with colleagues and employers and take part in reviews and investigations when requested. This includes being open and honest with their regulators and raising concerns where appropriate.

Any midwife who fails to discharge the duty or stops someone from raising concerns will be held to account.

Conclusion

All midwives are now subject to a professional duty of candour set out in

the revised Code issued by the NMC (2015) that reflects the joint statement on candour issued by all professional regulators for health and social care (GMC, 2014). It imposes on midwives a duty to be open and honest with women about errors that may cause them harm or distress and a duty to raise concerns and allow others to raise concerns.

Midwives in England are subject to a further organisational duty of candour imposed under the Health and Social Care Act (2008) (Regulated Activities) Regulations (2014), regulation 20, that requires a midwifery service to give an explanation and apology to a woman following a notifiable safety incident.

The aim of the statutory and professional duty of candour is to promote openness in maternity services that will protect women and improve public confidence in the profession. Midwives must ensure they discharge their duty of candour to protect the women and babies in their care. **BJM**

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