

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

A draft for consultation

NMC Nursing &
Midwifery
Council

General
Medical
Council

The professional duty of candour*

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.

This means that healthcare professionals must:

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

Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. Healthcare professionals 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.

* General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Nursing & Midwifery Council, Pharmaceutical Society of Northern Ireland (2014) The professional duty of candour available at: www.gmc-uk.org/Joint_statement_on_the_professional_duty_of_candour_FINAL.pdf_58140142.pdf (accessed 29 October 2014)

About this guidance

- 1 All healthcare professionals have a duty of candour – a professional responsibility to be honest with patients* when things go wrong. This is set out in *The professional duty of candour*,† which prefaces this guidance and which forms part of a joint statement from eight regulators of healthcare professionals in the UK.
- 2 As a doctor, nurse or midwife, you must be open and honest with patients, with colleagues, and with your employers. If something goes wrong when you are providing care, you must report it whether or not it leads to actual harm.
- 3 This guidance builds on the joint statement from the healthcare regulators and gives more information about how to comply with the principles set out in *Good medical practice*¹ and *The Code: Standards of conduct, performance and ethics for nurses and midwives*². Appendix 1 sets out relevant extracts from General Medical Council (GMC) and Nursing and Midwifery Council (NMC) guidance. It applies to all doctors registered with the GMC and all nurses and midwives registered with the NMC throughout the UK.
- 4 The guidance is divided into two parts.
 - a Your duty to be open and honest with patients or those close to them, if something goes wrong, including advice on apologising (paragraphs 6–20).
 - 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 21–30).
- 5 Throughout the guidance we talk about your responsibilities towards patients or people in your care. We recognise that care is often provided by multidisciplinary teams and that you may be one of several healthcare professionals involved in a patient's care. We would not expect every member of a healthcare team to talk to the patient. But you must make sure that an appropriate person – usually the lead or accountable clinician – takes responsibility for speaking to the patient or those close to them if something goes wrong.

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

† General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Nursing & Midwifery Council, Pharmaceutical Society of Northern Ireland (2014) *The professional duty of candour* available at: www.gmc-uk.org/Joint_statement_on_the_professional_duty_of_candour_FINAL.pdf_58140142.pdf (accessed 29 October 2014)

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

Do what you can before beginning treatment

- 6 Patients in your care must be fully informed about all the elements of their treatment. When discussing treatment options with patients, you must discuss the risks as well as the benefits of any options.
- 7 You or an appropriate person* must have a clear and comprehensive conversation with the patient about risks. You should discuss risks that occur commonly, those that are serious, and those that the patient is particularly concerned about, so the patient is aware of the potential for adverse outcomes when giving consent to treatment or investigation.

What to do if something goes wrong

- 8 As soon as you recognise that something has gone wrong and a patient in your care has suffered physical or psychological harm or distress, you should do what you can to put matters right immediately.^{3, 4}
- 9 You must then speak to the patient, unless you are sure that another, appropriate member of the healthcare team is taking on this responsibility.
- 10 You[†] should first tell the patient that something has gone wrong with their care and give them the opportunity to say they do not want to be given any more information. Most patients will want to know more about what has gone wrong. But, if the patient does not want more information, you should try to find out why. If, after discussion, the patient insists they do not want more information, you should respect their wishes as far as possible,[‡] having explained the potential consequences. You must record the fact that the patient does not want this information and make it clear to the patient that they can change their mind and have more information at any time.

* See paragraphs 26–27 of *Consent: patients and doctors making decisions together*.⁵

† When working in multidisciplinary teams, you must make sure that an appropriate person from the team – usually the lead or accountable clinician – is taking responsibility for talking to the patient or those close to them about what has happened. Not every member of a team will need to speak to the patient.

‡ 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.⁶

11 You should speak to patients as soon as possible after you realise something has gone wrong with their care, and you are able to give them some information about what has happened and the likely short-term and long-term effects. You should share all the information you have, explain if anything is still uncertain and respond honestly to any questions.⁷

Saying sorry

12 If someone in your care has suffered harm or distress because something has gone wrong, then you should apologise as soon as you become aware of this.^{8,9}

13 When apologising to a patient – or those close to the patient – you should consider the following.

- a** You must share information in a way that the patient can understand and, whenever possible, in a place and at a time when they are best able to understand and retain it.
- b** You should give information that the patient may find distressing in a considerate way, and respect your patient's right to privacy and dignity, making sure that conversations take place in appropriate settings where possible.
- c** Patients and those close to them are likely to find it more meaningful if you accept personal responsibility for something going wrong, rather than offer a general expression of regret about the incident.

d Patients and those close to them expect to be told three things as part of an apology:

- i** what happened
- ii** what can be done to deal with any harm caused
- iii** what will be done to prevent someone else being harmed.¹⁰

e You should make sure the patient knows who to contact in the healthcare team to ask any further questions or raise concerns.

f You should record the details of your apology in the patient's clinical record.^{11,12} A verbal apology may need to be followed up by a written apology, depending on the patient's wishes (or the wishes of those close to the patient), and your workplace policy.

14 If you do not feel able to apologise to the patient, or those close to them, with the required tact and sensitivity, you should:

- a** make sure that an appropriate member of the team takes on the responsibility to talk to the patient
- b** undergo training as soon as possible to develop your skills and experience in this area.

15 You do not have to wait until the outcome of an investigation to apologise to a patient, or someone close to them, when something has gone wrong. But you should be clear that the facts have not yet been established, tell them only what you know and believe to be true, and answer any questions honestly and as fully as you can.

Speaking to those close to the patient

16 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 those close to the patient.^{13, 14} Take time to convey the information in a compassionate way, giving them the opportunity to ask questions at the time and afterwards.*

17 You must show respect for, and respond sensitively to, the wishes and needs of bereaved people, 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 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.^{†, 18}

18 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

19 You must use your professional judgement when considering whether to inform patients about near misses – adverse events that did not result in injury, illness, harm or damage, but had the potential to do so. Often there will be information that the patient would want or need to know about and, in these cases, you should talk to the patient about the near miss, following the guidance in paragraphs 8–15.

20 Some patients will want to be informed about near misses, and failure to be open could damage their trust in you and the healthcare team. However, in some circumstances, patients do not need to know about something that has not caused (and will not cause) them harm, and telling them may distress or confuse them unnecessarily. If you are not sure about whether to talk to a patient about a near miss, seek advice from a senior colleague.

* 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.¹⁵

† For information about patient and carer support and advocacy services, counselling and chaplaincy services, and clinical ethics support networks, see the advice and resources listed on the National End of Life Care Programme website¹⁶ and the PallCareNI website.¹⁷

Encouraging a learning culture by reporting errors

- 21** When things go wrong with patient care, the cause is usually either a flaw in an organisational system or human error. It is crucial that errors are reported at an early stage to put matters right and to learn any lessons so that future patients may be protected from harm.
- 22** Healthcare organisations should have a policy for reporting adverse incidents¹⁹ and you must follow your organisation's policy. This means reporting incidents that lead to harm as well as reporting near misses: adverse incidents that did not result in injury, illness, harm or damage, but had the potential to do so.
- 23** A number of reporting systems and schemes exist around the UK for reporting adverse incidents and near misses.
- a** Adverse events and patient safety incidents in England and Wales are reported to the National Reporting and Learning System.²⁰
 - b** You must report suspected adverse drug reactions to the UK-wide Yellow Card Scheme run by the Medicines and Healthcare products Regulatory Agency (MHRA) and the Commission on Human Medicines.²¹
 - c** You must report adverse incidents involving medical devices to the UK-wide MHRA reporting system.²²
 - d** Healthcare Improvement Scotland has instigated a national framework,²³ which outlines consistent definitions and a standardised approach to adverse event management across National Health Service (NHS) for Scotland.
 - e** The procedure for the management and follow-up of serious adverse incidents in Northern Ireland is set out on the Department of Health, Social Services and Public Safety's website.²⁴
- 24** 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 (see paragraphs 29–30 on the organisational duty of candour). If your organisation does not have such a system in place, you must speak to your manager and raise the concern in line with our guidance.^{25, 26}
- 25** You must take part in regular reviews and audits^{27, 28} of the standards and performance of any team you work in, taking steps to resolve any problems.

Additional duties for doctors, nurses and midwives with management responsibilities and for senior or high profile clinicians^{29, 30}

- 26** 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.
- 27** 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.
- 28** 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:
 - lessons are learned from analysing adverse incidents and near misses
 - lessons are shared with the healthcare team
 - concrete action follows on from learning
 - practice is changed where needed.

The organisational duty of candour

- 29** All healthcare organisations have a duty to support their staff to report adverse incidents, and to support staff to be open and honest with patients if something goes wrong with their care. Each of the four UK governments is considering ways to implement the organisational duty of candour, with some writing it into law (see appendix 2).
- 30** If systems are not in place in your organisation to support staff to report adverse incidents, you should speak to your manager or a senior colleague and, if necessary, escalate your concern in line with our guidance on raising concerns.^{25, 26}

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

From *Good medical practice*^{1,19}

- 23** 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 that put or have the potential to put the safety of a patient, or another person, at risk
 - d** report suspected adverse drug reactions
 - e** respond to requests from organisations monitoring public health.

When providing information for these purposes you should still respect patients' confidentiality.

- 24** You must promote and encourage a culture that allows all staff to raise concerns openly and safely.
- 55** You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:
- a** put matters right (if that is possible)
 - b** offer an apology
 - c** explain fully and promptly what has happened and the likely short-term and long-term effects.

From *Raising and acting on concerns about patient safety*²⁵

- 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 doctor in training, it may be appropriate to raise your concerns with a named person in the deanery – for example, the postgraduate dean or director of postgraduate general practice education.

Also see the raising concerns decision making tool on the GMC website.³¹

From *Leadership and management for all doctors*³⁰

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

All doctors

- 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.

Doctors 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 *Consent: patients and doctors making decisions together*⁵

75 In making decisions about the treatment and care of patients who lack capacity, you must:

- a** make the care of your patient your first concern
- b** treat patients as individuals and respect their dignity
- c** support and encourage patients to be involved, as far as they want to and are able, in decisions about their treatment and care
- d** treat patients with respect and not discriminate against them.

76 You must also consider:

- a** whether the patient's lack of capacity is temporary or permanent
- b** which options for treatment would provide overall clinical benefit for the patient
- c** which option, including the option not to treat, would be least restrictive of the patient's future choices
- d** any evidence of the patient's previously expressed preferences, such as an advance statement or decision
- e** the views of anyone the patient asks you to consult, or who has legal authority to make a decision on their behalf, or has been appointed to represent them

f the views of people close to the patient on the patient's preferences, feelings, beliefs and values, and whether they consider the proposed treatment to be in the patient's best interests

g what you and the rest of the healthcare team know about the patient's wishes, feelings, beliefs and values.

From Treatment and care towards the end of life: good practice in decision making¹⁸

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: Standards of conduct, performance and ethics for nurses and midwives³²

Preserve Safety

Nurses and midwives seek to ensure that patient and public safety is not compromised, working within the limits of your competence, exercising your professional duty of candour and raising concerns immediately whenever you encounter situations that put patients or public safety at risk.

14 Exercise candour and be transparent with all service users about all aspects of care and treatment, including when any errors have occurred.

To achieve this, you must:

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

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

14.3 document all such events formally and escalate them as appropriate to enable them to be acted on quickly.

19 Be aware of, and minimise, any potential for harm associated with your practice.

To achieve this, you must:

19.1 consider how you can take measures to minimise the likelihood of errors, near misses and the impact of harm if it occurs.

19.2 take account of current evidence, knowledge and developments in the reduction of human errors and the impact of human factors and system failures as contributory factors to errors.

Glossary

Candour – the ‘professional duty of candour’ is defined in the joint statement from the chief executives of statutory regulators of healthcare professionals entitled ‘Openness and honesty - the professional duty of candour’ published in October 2014 as follows:

“The Professional Duty of Candour

Every healthcare 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.

This means that healthcare professionals must:

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

Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. Health and care professionals 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.”

Near miss – an unplanned event that did not result in injury, illness, harm or damage but had the potential to do so.

Appendix 2: Variations in the organisational duty of candour across the UK

England

The Care Quality Commission is putting in place a new requirement for healthcare providers to be open with patients and apologise when things go wrong. This duty will initially apply to NHS healthcare bodies and will later be brought in for all other registered providers. The organisational duty of candour does not apply to individuals, but organisations providing healthcare will be expected to implement the new duty throughout their organisation by ensuring that staff understand the duty and are appropriately trained.

Northern Ireland

The Department for Health, Social Services and Public Safety is considering whether a statutory duty of candour is required. Professor Sir Liam Donaldson, former Chief Medical Officer for England, has been appointed to carry out an expert examination of whether governance arrangements ensure a high quality of health and social care. As part of the review, which is due to report by the end of 2014, Professor Donaldson has been asked to examine the Health and Social Care (HSC) Public Health Agency's:

- openness and transparency
- appetite for enquiry and learning
- approach to redress and making amends.

The examination will focus mainly on systems in trusts and across the HSC Public Health Agency that support identifying, reporting, investigating and learning from adverse incidents.

The examination will also consider the openness of the related processes in and across organisations,

particularly with service users and their families who are most affected by individual incidents.

Scotland

The Healthcare Quality Strategy for NHS Scotland³³ is aiming to achieve an NHS culture in which care is consistently person-centred, clinically effective and safe for every person, all the time.

The Scottish Patient Safety Programme (SPSP)³⁴ is a national initiative that aims to improve the safety and reliability of healthcare and reduce harm.

On 15 October 2014, the Scottish Government launched a consultation on a duty of candour for organisations providing health and social care, including health boards. The consultation, which covers disclosure, support, training and reporting, closes on 14 January 2015.

Wales

The *National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011* place a number of duties on responsible bodies. 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 the notification of the concern and involve the patient, or his or her representative, in the investigation of the concern.'

The Welsh Government has committed to making this organisational duty more explicit, in light of both the Francis report³⁵ and the Robert Powell Investigation.³⁶

References

- 1 General Medical Council (2013) *Good medical practice* available at: www.gmc-uk.org/gmp (accessed 16 October 2014), paragraphs 24 and 55
- 2 Nursing and Midwifery Council (draft, following consultation, as of October 2014, due for publication 2015) *The Code: Standards of conduct, performance and ethics for nurses and midwives* pp 7–8 and 18
- 3 General Medical Council (2013) *Good medical practice* available at: www.gmc-uk.org/gmp (accessed 16 October 2014), paragraph 55 a–c
- 4 Nursing and Midwifery Council (draft, following consultation, as of October 2014, due for publication 2015) *The Code: Standards of conduct, performance and ethics for nurses and midwives* p 6
- 5 General Medical Council (2008) *Consent: patients and doctors making decisions together* available at: www.gmc-uk.org/consent (accessed 16 October 2014)
- 6 General Medical Council (2008) *Consent: patients and doctors making decisions together* available at: www.gmc-uk.org/consent (accessed 16 October 2014), paragraphs 13–17
- 7 General Medical Council (2013) *Good medical practice* available at: www.gmc-uk.org/gmp (accessed 16 October 2014), paragraph 31
- 8 Nursing and Midwifery Council (draft, following consultation, as of October 2014, due for publication 2015) *The Code: Standards of conduct, performance and ethics for nurses and midwives* p 9
- 9 General Medical Council (2013) *Good medical practice* available at: www.gmc-uk.org/gmp (accessed 16 October 2014), paragraph 55b
- 10 NHS Litigation Authority *Saying Sorry* available at: <http://www.nhs.uk/Claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf> (accessed 16 October 2014)
- 11 Nursing and Midwifery Council (draft, following consultation, as of October 2014, due for publication 2015) *The Code: Standards of conduct, performance and ethics for nurses and midwives* paragraph 86
- 12 General Medical Council (2013) *Good medical practice* available at: www.gmc-uk.org/gmp (accessed 16 October 2014), paragraph 21c
- 13 Nursing and Midwifery Council (draft, following consultation, as of October 2014, due for publication 2015) *The Code: Standards of conduct, performance and ethics for nurses and midwives* paragraphs 33, 101 and 105
- 14 General Medical Council (2013) *Good medical practice* available at: www.gmc-uk.org/gmp (accessed 16 October 2014), paragraphs 33, 65 and 68
- 15 General Medical Council (2013) *Good medical practice* available at: www.gmc-uk.org/gmp (accessed 16 October 2014), paragraph 34
- 16 National Health Service *Improving Quality End of Life Care* archived website available at: www.nhs.uk/legacy-websites/end-of-life-care.aspx (accessed 21 October 2014)
- 17 PallCareNI *Understanding Palliative and End of Life Care* available at: www.pallcareni.net (accessed 21 October 2014)
- 18 General Medical Council (2010) *Treatment and care towards the end of life: good practice in decision making* available at: www.gmc-uk.org/endoflife (accessed 16 October 2014), paragraph 84
- 19 General Medical Council (2013) *Good medical practice* available at: www.gmc-uk.org/gmp (accessed 16 October 2014), paragraph 23
- 20 National Health Service *Report a patient safety incident* available at: www.nrls.npsa.nhs.uk/report-a-patient-safety-incident (accessed 21 October 2014)
- 21 Medicines and Healthcare products Regulatory Agency *Yellow Card: Helping to make medicines safer* available at: <https://yellowcard.mhra.gov.uk> (accessed 21 October 2014)
- 22 Medicines and Healthcare products Regulatory Agency *Reporting adverse incidents involving medical devices* available at: www.mhra.gov.uk/Safetyinformation/Reportingsafetyproblems/Devices/index.htm (accessed 21 October 2014)

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- 23 Healthcare Improvement Scotland (2013) *Learning from adverse events through reporting and review: A national framework for NHS Scotland* available at: www.healthcareimprovementscotland.org/our_work/governance_and_assurance/management_of_adverse_events/national_framework.aspx (accessed 21 October 2014)
- 24 Department of Health, Social Services and Public Safety *Procedure for the Management and Follow up of Serious Adverse Incidents* available at: www.dhsspsni.gov.uk/saibackground (accessed 21 October 2014)
- 25 General Medical Council (2012) *Raising and acting on concerns about patient safety* available at: www.gmc-uk.org/raisingconcerns (accessed 16 October 2014)
- 26 Nursing and Midwifery Council (2013) *Raising and concerns: guidance for nurses and midwives* available at: www.nmc-uk.org/documents/nmc-publications/nmc-raising-and-escalating-concerns.pdf (accessed 16 October 2014)
- 27 Nursing and Midwifery Council (draft, following consultation, as of October 2014, due for publication 2015) *The Code: Standards of conduct, performance and ethics for nurses and midwives* paragraph 47
- 28 General Medical Council (2013) *Good medical practice* available at: www.gmc-uk.org/gmp (accessed 16 October 2014), paragraphs 22–23
- 29 Nursing and Midwifery Council (draft, following consultation, as of October 2014, due for publication 2015) *The Code: Standards of conduct, performance and ethics for nurses and midwives* paragraphs 6 and 9–10
- 30 General Medical Council (2012) *Leadership and management for all doctors* available at: www.gmc-uk.org/leadership (accessed 16 October 2014)
- 31 General Medical Council *Raising and acting on concerns about patient safety: decision making tool* available at: www.gmc-uk.org/guidance/ethical_guidance/decision_tool.asp (accessed 16 October 2014)
- 32 Nursing and Midwifery Council (draft, following consultation, as of October 2014, due for publication 2015) *The Code: Standards of conduct, performance and ethics for nurses and midwives*
- 33 The Scottish Government (2010) *NHS Scotland Quality Strategy – putting people at the heart of our NHS* available at: www.scotland.gov.uk/Publications/2010/05/10102307/0 (accessed 16 October 2014)
- 34 Scottish Patient Safety Programme available at: www.scottishpatientsafetyprogramme.scot.nhs.uk (accessed 16 October 2014)
- 35 The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) *The Mid Staffordshire NHS Foundation Trust Public Inquiry: final report* available at: www.midstaffpublicinquiry.com/report (accessed 16 October 2014)
- 36 Welsh Government (2012) *The Robert Powell Investigation* available at: <http://wales.gov.uk/topics/health/publications/health/reports/powell/?lang=en> (accessed 16 October 2014)

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