Duty of Candour Policy

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<th>Reference number</th>
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<td>Version</td>
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<tr>
<td>Author Name &amp; Job Title</td>
<td>Danielle Boyd, SI Investigation Team</td>
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<td>Policy Review Group/ 9th November 2015</td>
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<td>Quality and Safety Group</td>
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CONTRIBUTION LIST

Key individuals involved in developing this version of the document

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Approved by Group/ Committee: PRG- 9th November 2015
Ratified by Group/Committee: QSG- 16th November 2015

Change History

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<th>Date</th>
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<tr>
<td>Version 1</td>
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<td>New Policy</td>
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<tr>
<td>2</td>
<td>October 2015</td>
<td>Danielle Boyd, SI investigation Lead</td>
<td>Formal update to reflect change to SI process.</td>
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**Introduction**

Central to West Hertfordshire NHS Trust’s (The Trust) strategy to improve patient safety is our commitment to improving communication between healthcare professionals / teams and patients, families and/or carers when a patient is harmed as a result of a patient safety incident (Being Open NPSA 2009).

The publication of the Francis Inquiry Report in 2013 instigated a great many changes to health care and the way we do things. The drive to improve transparency and openness within the NHS and to provide assurance to our patients, families and/or carers that we are doing everything we can to keep them safe has never been higher on the agenda.

In addition to the above, and as a result of the Francis Inquiry, there is also a requirement under the NHS Standard Contract issued by the NHS Commissioning Board, to ensure that patients, families and/or carers are told about patient safety events that affect them, to receive an appropriate apology and to be kept informed about investigations under the Contractual Duty of Candour. This requirement does apply to unavoidable, but unexpected significant complications of treatment regardless of whether the complication was discussed as part of the consent process.

In October 2014 under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 20, the Department of Health introduced the Statutory Duty of Candour in addition to registration requirements with the Care Quality Commission. This statutory Duty of Candour applies to organisations and goes beyond the professional Duty of Candour required by individual healthcare professionals. Draft guidance on the professional Duty of Candour is available and where applicable has been incorporated into this policy.

Providers must promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. There should also be a commitment to being open and transparent at board level (CQC, 2015).

This policy provides assurance that frameworks exist within the Trust.

1 **Definitions**

Key definitions - as defined by the CQC (2015):

- **Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered

- **Transparency** – allowing information about the truths about performance and outcomes to be shared with staff, patients, the public and regulators.

- **Candour** – any patient harmed by the provision of healthcare services is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it

It is important to note that the Duty of Candour requirements apply to all situations of **significant unexpected harm**. This includes incidents which may be avoidable and complications of treatment whether avoidable or not. Progression of the patient’s underlying condition does not require the Duty of Candour process to be followed.

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The requirement to offer the patient or family a letter detailing the discussion is a contractual requirement placed on WHHT by our commissioning CCG and is a National requirement.

The harm matrix informs selection of the appropriate communication process and is based on the harm assessment descriptors in the Incident Reporting Policy. *(Table 1 below)*

<table>
<thead>
<tr>
<th>Harm assessment</th>
<th>Impact on patient</th>
<th>Communication process</th>
</tr>
</thead>
<tbody>
<tr>
<td>No harm</td>
<td>No impact</td>
<td>Being open</td>
</tr>
<tr>
<td>Minor harm</td>
<td>Requires additional monitoring, minor intervention or will require up to a week to heal the injury</td>
<td>Being open</td>
</tr>
<tr>
<td>Moderate harm</td>
<td>Requires significant intervention to save life or limb; or requires additional surgery; or an escalation in care due to the incident; or results in cancellation of treatment; or will require between a week, and a month to heal from the injury; or will result in avoidable pain or anxiety that last for more than 28 days or more</td>
<td>Duty of Candour</td>
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<tr>
<td>Severe harm</td>
<td>permanent</td>
<td>Duty of Candour</td>
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<tr>
<td>death</td>
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2 Objectives

The purpose of this policy and procedure is to provide guidance to staff with regard to open and honest communication with patients, their families and carers when an event causing unexpected harm occurs. Communication should be as soon as possible following the event and will continue for as long as it is necessary to support openness with patient, family and/or carers.

This policy sets out the standards for communicating with a patient, family and/or carers following a reportable patient safety incident or unexpected complication and should be read in conjunction with the Incident Reporting Policy. The Duty of Candour requirements apply to significant complications of treatment, whether these were avoidable or not, and whether the complication was included in the consent process or not.

This document outlines the Trust’s policy on Duty of Candour and the processes by which openness will be supported, thereby supporting the Trust in meeting its obligations to be open and honest about any mistakes that are made whilst Trust staff care for and treat patients. Openness and transparency with our patients and their families is a core Trust value, and this document supports further developments to ensure that when we are open and transparent with patients and their families we take care to help them to understand the event and how we will review it. While the focus of this policy is on communication with patients, their families and carers it is important to note that open, appropriate and timely communication with our service users requires individual members of staff to be open about possible patient safety incidents or unexpected complications with their colleagues and managers.
All possible unexpected events resulting in harm must be reported on an incident report form promptly as this will allow effective escalation when required and robust record keeping. It is accepted that some of these events will be unavoidable and that some of them will not represent actual incidents. Any concerning events resulting in harm should also be verbally reported to senior colleagues as a matter of urgency.

3 Scope

This policy is relevant to all care delivered by any of the Trust’s clinical services to patients, their families and carers. In line with national guidance the specific statutory Duty of Candour applies to actual or suspected patient safety events that occur during care provided and that result in, or are suspected to result in, moderate harm, severe harm or death, and prolonged psychological harm. The professional Duty of Candour extends to all incidents, regardless of the degree of harm caused, and should be perceived as a standard to guide communication. Please note that while the professional Duty of Candour applies to all incidents, the statutory Duty of Candour applies to all events that result in harm, whether this was an unexpected complication or an actual incident. The Duty of Candour would include legacy incidents that had not been identified at the time of the incident. These Duty of Candour requirements will be decided on an individual basis with the SI team liaising with the CCG and Executive Leads.

In some circumstances the cause of the harm may not be known and so a DoC lead will still be identified. Details of the DoC lead should be kept on Datix. The SI team can provide advice to the nominated individual.

While WHHT encourages staff to be open about all events that could have impacted on patients we will only require staff to discuss these events where harm has been caused. These cases will likely be SI and covered by the SI process.

For quality assurance suggest the division’s evidence this communication using the designated communication record (appendix 5)

4 Policy statement

A key principle for WHHT NHS Trust is that the Trust and everyone working for us must be honest, open and truthful in all their dealings with patients, families and carers and the public, and organisational and personal interests must never be allowed to outweigh the duty to be open, honest and truthful. This expectation has been in place since the development of our Being Open Policy.

We believe that where an event has led to harm, patients, their families and carers should receive an explanation and apology as soon as possible after the event occurred and that staff should feel able to apologise there and then.

Where the event results in more serious harm the requirements for Duty of Candour must be applied. It is important that the patient, their families and carers are notified as soon as possible. This may be before we have confirmed that there has been an actual error or lapse which resulted in harm to the patient.

This may also be before we have confirmed that the harm has been caused (Herts Valleys CCG). We have a contractual obligation to ensure that the patient or their family have been informed about events that have caused significant harm within a maximum of 10 days of our knowledge of the event.

Saying sorry does not amount to an admission of liability and it is the right thing to do. Patients, families and carers have a right to expect openness in their healthcare.

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6 Responsibilities

6.1 All Staff
- All staff are expected to adhere to this policy and to promote an open and fair culture
- Staff should be aware of their responsibility to acknowledge and report incidents as soon as they are identified
- Where patients and or their carers inform staff that a patient safety incident has occurred, they should take this seriously and act with compassion and understanding;
- Junior staff or those in training may be involved in the Being Open process described below but should not lead the process unless the incident is assessed as a low harm event, the senior healthcare professional responsible for care is present for support

6.2 Chief Executive
The chief executive has overall responsibility for Governance within the Trust including ensuring a framework is in place to support openness between healthcare professionals and patients and/or their carers following a patient safety incident and for championing a Being Open culture.

6.3 Trust Board
The Board publically endorse the principles described in this document and is ultimately responsible for ensuring that the organisation communicates openly and honestly with patients, families and carers when an incident occurs. The Board is also ultimately responsible for ensuring that the culture at WHHT is one that allows transparency and openness to flourish.

6.4 Chief Nurse
The Chief Nurse has delegated responsibility for Governance within the Trust and is the nominated Executive Lead for championing and implementing the principles of Being Open.

6.5 Patient Safety Quality and Risk Committee
The Patient Safety Quality Risk Committee has overall responsibility for the Being Open process. As a subgroup of the Board of Directors, this Committee will be responsible for providing assurance on the implementation and effectiveness of this policy, ensuring the document is updated in accordance with national and local initiatives.

6.6 Clinical Directors / Lead Clinician / Heads of Nursing / Department Leads
The Clinical Director / Lead Clinician / Head of Nursing / Department Lead are responsible for:

- identifying the most appropriate member of staff, normally a Consultant, Head of Nursing, Lead Nurse or Ward Sister but always a person with appropriate seniority and/or experience, to meet with a patient and/or their carer following a patient safety incident;
- Providing feedback and support to staff involved in a patient safety incident or in the Being Open process
- Providing support to staff involved in a patient safety incident which has or may result in a complaint and/or claim being made.
6.7 PALS & Complaints Manager and Claims and Legal Manager
The PALS & Complaints Manager and Claims and Legal Manager are responsible for ensuring that Complaints and Claims processes support a culture of Being open.

7 Procedure and Duty of Candour Communication requirements

8 Incident detection or recognition

The Being Open process begins with the recognition that a patient has suffered harm or has died as a result of a patient safety incident. A patient safety incident may be identified by:

- A member of staff at the time of the incident
- A member of staff retrospectively when an unexpected outcome is detected
- A patient, their family or carer who expresses concern or dissatisfaction with the patient’s healthcare at the time of the incident or retrospectively
- Incident reporting or medical records review
- At Specialist Mortality notes review

8.1 Clinical Care

When a patient has been harmed the immediate priority is to ensure that prompt and appropriate clinical care is initiated to prevent further harm. Where additional treatment is required, this should be discussed with the patient if possible or with their carer if the patient is unable to participate.
Consent must be sought in accordance with the Trust’s Consent Policy.

9 Reporting

9.1 Whether a patient safety incident is recognised by a member of staff, patients, their family or carer as it occurs or as a result of a complaint or legal claim, the incident should be reported as soon as it has been identified using a risk event form (Datix) in accordance with the Incident Policy.

9.2 Where a patient, their family or carer informs clinical staff directly of an incident, these concerns should be taken seriously, investigated and treated with compassion.

9.3 Where an incident is identified as having occurred in another organisation, the Trust’s Head of Governance should contact their equivalent at the organisation where the incident occurred and establish whether:

- The incident has already been recognised;
- The Being Open process has commenced;
- An incident investigation is underway.

9.4 Criminal or unsafe acts

Patient safety incidents are almost always unintentional. However if at any stage following an incident it is determined that harm may have been the result of a criminal or intentional unsafe act, the Head of Governance or Chief Nurse and Medical Director must be informed immediately.

Reference to the NPSA Incident Decision Tree may offer assistance in determining appropriate action by managers. Available at: http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59900.

10 Preliminary team discussion

10.1 Prior to the initial meeting with the patient, their family or carer, the appropriate members of the multidisciplinary team should meet as soon as possible after the incident to establish:

- the clinical and other facts ensuring a consistent approach;
- the level of response required as determined by the severity if the harm caused (refer to table 1);
- the lead member of staff for communicating with the patient, their family and carers;
- the timing of the discussion;
- the need for any patient support at this stage (this might include the use of a facilitator or a patient advocate;
- The immediate support needs of the healthcare staff involved.

10.2 If there is disagreement amongst the multidisciplinary group about any of the facts, communication about these issues should be deferred until after the investigation is completed.
Reference to the NPSA Incident Decision Tree may offer assistance in determining appropriate action by managers. Available at: http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59900.

10.3 The identified lead, will normally be the most senior person responsible for the patient’s care; the patient’s consultant. They should have expertise in the type of incident that has occurred, good interpersonal skills, knowledge of the facts relevant to the incident and be available for ongoing communication.

10.4 The lead should be supported by at least one other member of staff such as the Clinical Directors / Lead Clinician / Heads of Nursing / Department Leads or other member of the healthcare team experienced in the Being Open process. Consideration should be given to the communication skills of the team members to ensure clear, effective and sympathetic discussions take place.

10.5 Where the lead is not known to the patient, a member of staff such as the patient’s ‘named nurse’ should be present to offer support.

10.6 Where the patient safety incident relates to non clinical issues, the senior manager responsible for that area of service should lead the communication with the patient and/or their carer, with support from the healthcare professional treating the resultant injury.

10.7 Where a member of the healthcare team is directly responsible for the error that resulted in harm, they may or may not wish to participate in the Being Open discussion. Each case should be considered individually balancing the needs of the patient, their family or carers with those of the healthcare professional concerned. If the healthcare professional wishes to attend in order to offer a personal apology, they should be supported by their colleagues throughout the meeting. If the patient, their family or carer expresses a preference that the healthcare professional should not attend the meeting, this should be respected and a written apology should be offered.

10.8 The patient, their family or carer should be asked who they would like to be present and if during the discussion it clear they would prefer to speak to a different healthcare professional, those wishes should be respected. The involvement of a facilitator or patient advocate may be considered. Where there are language difficulties a translator may be provided. Language Line can be contacted via the switchboard.

10.9 The meeting should be held as soon as possible after the incident with consideration for the patient’s, their family’s or carer’s circumstances including the patient’s preference, patient’s clinical and emotional condition and availability the patient’s family or carer and of key staff such as a translator or advocate. The patient should be offered a choice of times. Once arranged, the meeting should not be cancelled other than in exceptional circumstances.

10.10 The meeting should be held in a suitable, quiet area away from the place where the incident occurred, within the limits of the patient’s clinical needs, and there should be no opportunity for interruptions. In some cases it may be appropriate to hold the meeting in the patient’s own home.

10.11 Meetings should be attended by key Trust representatives only, so as not to overwhelm the patient, carer or advocate.
11 Initial being open discussion with patient carer or relative

Notify the patient, family and/or carers within 10 working days of the incident being reported to local systems and sooner where possible. This notification should ideally be done face to face, or if not practical, by telephone. If there are language/ literacy or cognitive barriers that could impact on this discussion then an interpreter or suitable support must be arranged. (See appendix 1)

- Provide a meaningful apology.
- Provide the patient, family and/or carers with all the information directly relating to the incident which is currently known.
- Ask for confirmation of any questions that the patient, family or carer may have.
- Provide details of the investigation plan if known.
- Provide reasonable support following the incident.

This initial discussion will in most cases be held by members of the clinical team who were treating the patient.

A commitment must be made to provide further updates and the patient, family or carer should be offered a letter summarising the discussion. (See appendix 2). The patient, family or carer should be asked to confirm how they would like to receive updates. The requirement to offer the families a copy of this update in writing is a contractual requirement. The discussion should introduce the external support services to the patient, relative or carer. (See appendix 3)

12 Follow up discussions with the patient, carer or relative

Depending on the circumstances of the incident and the timescales identified, there may be more than one follow up meeting however patients, their families and carers must be kept informed of progress in accordance with the arrangements made at the initial meeting.

In order to ensure effective communication:

- Follow up should occur as soon as practicable;
- Timing and location of meetings should be based on the patient's health and personal circumstances;
- Written records of discussion should be offered;
- There should be appropriate response to queries;
- There should be no speculation or blame attributed.
13 Process completion

Feedback on the investigation should ideally be provided face to face wherever possible, however, it is noted that this may not be practical on many occasions. If a face to face meeting cannot be held then consideration should be given to using teleconference facilities or holding a scheduled telephone call.

The patient, family or carer should be offered a letter summarising the investigation findings and detailing action that we will take arising from that investigation.

Feedback should include the investigation findings, responses to any questions raised by the patient, family or carer, details of action that we will take following the investigation and a further apology for any harm and/or distress caused.

This should be followed up with a feedback letter (see appendix 4).

14 Documentation

14.1 Documentation associated with the investigation and analysis should be stored in accordance with the Incident Policy.

14.2 A complete and accurate record of all discussions must be entered in the patient’s notes. The Trust Feedback Record template may be used for this purpose where appropriate (refer to appendix 5 for appropriate Paediatric or Adult). This record should be signed and dated and include:

- a brief summary of the information given;
- the patient’s, their family’s or carer’s reaction;
- any remaining questions the patient, their family or carer raised and the responses given;
- Offers of assistance
- What will happen next.

14.3 Key points, action points, assigned responsibilities and deadlines should be confirmed in writing.

14.4 If the family have declined the DoC process then staff must document this clearly in the patient notes using the feedback record including details of the conversation.

15 Continuity of Care

15.1 Where a patient safety incident has resulted in harm, the patient, their family or carer should be informed of the on-going clinical management plan. If appropriate, these details should be included in the discharge summary provided to designated individuals such as the GP, district nursing service or other healthcare organisation responsible for any on-going care needs.
15.2 The patient, their family or carer should be reassured that they will continue to be treated according to their clinical needs, even in circumstances where there is a dispute between them and the healthcare team. They should also be informed they have the right to continue their treatment elsewhere if they have lost confidence in the healthcare team involved in the patient safety incident.

16 External communication

16.1 GP, Community Care Service Providers or other NHS Organisations

Wherever possible, it is advisable to send a brief communication to the patient’s GP before discharge, describing what happened so that they may offer their support.

16.2 When the patient is transferred or discharged from the Trust, a discharge summary should be forwarded to the GP or appropriate community care provider summarising the nature of the incident and continuing care and treatment plans;

17 Support for staff involved in the investigation of a patient safety incident

Any member of staff involved in the investigation of an adverse incident can obtain advice and support from their line manager or the integrated governance team. If a member of staff is particularly distressed or requires professional support, this can be obtained via their line manager from the Occupational Health Department.

Each case is assessed on an individual basis, and support such as counselling may be offered. For further details please refer to the Supporting Staff involved in a Traumatic Incident, Complaint or Claims Policy.

18 Confidentiality

18.1 Wherever staff are following the process for open communication following a patient safety incident, full consideration should be given to the patient’s and the relevant staff member’s privacy and dignity. Identifiable details relating to patients or staff involved in a patient safety incident will be considered confidential at all times and shared on a need to know basis only in accordance with the Trust’s Confidentiality Policy and Sharing Patient Information Policy and in line with the Data Protection Act Principle 3.

18.2 Where lessons learnt are shared for the purpose of improving service provision, the details must be anonymised.

19 Evaluation measures

19.1 Standards/Key Performance Indicators

Number of incidents and complaints with moderate or severe harm levels, or death.

Of these:
- Initial contact made within 10 days (100%)
- Initial meeting conducted within two weeks (100%)
- Follow up letter completed (100%)
- Letter includes all criteria (100%)
19.2 **Audit & Review**

This policy will be formally reviewed by the author every 3 years from the date of ratification.

20 **Equality Impact Assessment Statement**

West Hertfordshire Hospital NHS Trust has made every effort to ensure this policy does not have the effect of discriminating, directly or indirectly, against employees, patients, contractors, or visitors on the grounds of race, colour, age, nationality, ethnic (or national) origin, gender, sexual orientation, marital status, religious belief or disability. This policy will apply equally to full and part time employees. All West Herts Hospital NHS Trust policies can be provided in large print or Braille formats if requested, and language line interpreter services are available to individuals who require them.
**Standard Equality Impact Assessment Tool**

<table>
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<th>Persons likely to be affected by policy change / implementation</th>
<th>Staff</th>
</tr>
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</table>

Are there concerns that the proposed documentation / change could have an adverse impact on:

- **Race, Ethnicity, National Origin, Culture, Heritage**  
  - N
- **Religion, Faith, Philosophical Belief**  
  - N
- **Gender, Marital Status, Pregnancy**  
  - N
- **Physical or Learning Disabilities**  
  - N
- **Mental Health**  
  - N
- **Sexual Orientation / Gender Reassignment**  
  - N
- **Age**  
  - N
- **Homelessness, Gypsy / Travellers, Refugees / Asylum Seekers**  
  - N

Please give details of any adverse impact identified:

If adverse impacts are identified, are these considered justifiable? (Please give reasoning)

There is unlikely to be an adverse impact on different minority groups

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<tr>
<th>Name of Person completing Ratification Form</th>
<th>Job Title</th>
<th>Date</th>
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<tr>
<td>Danielle Boyd</td>
<td>SI Investigation lead</td>
<td>October 2015</td>
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<th>Chair</th>
<th>Signature</th>
<th>Date</th>
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<tbody>
<tr>
<td>Quality and Safety Group</td>
<td>Tracey Carter</td>
<td></td>
<td>16.11.15</td>
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</tbody>
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21 References

Care Quality Commission: *Guidance for providers on meeting the fundamental standards and on CQC enforcement powers* July 2014
www.legislation.gov.uk/ukdsi/2014/9780111117613/contents
Accessed September 2014

NPSA Patient Safety Alert *Being Open: communicating with patients, their families and carers following a patient safety incident* NPSA/2009/PSA003 Available at:

NPSA *Being Open Framework: saying sorry when thing go wrong* Available at:
http://www.nrls.npsa.nhs.uk/resources/collections/being-open/?entryid45=65077 Accessed July 2010


Making decisions: The Independent Mental Capacity Advocate (IMCA) service, OPG606, 2007

Mid Essex Hospital NHS Trust – Being open & Duty of candour Policy

Birmingham Children’s Hospital NHS foundation- Duty of Candour and being open Policy. Ratified - August 2015: review 2018

22 Related Policies

- Incident and Serious Incidents Policy- WHHT: G004
- Risk Management Procedure- a useful guide to staff- WHHT: G048
APPENDIX 1  Particular Patient Circumstances

NPSA, Being open: Communicating patient safety incidents with patients, their families and carers (2009).

Particular patient circumstances

The Trust’s approach to Being Open may need to be modified according to the patient’s personal circumstances. The following gives guidance on how to manage different categories of patient circumstances.

1. When a patient dies

When a patient safety incident has resulted in a patient’s death it is even more crucial that communication is sensitive, empathic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened. The patient’s family and carers will probably need information on the processes that will be followed to identify the cause(s) of death. They will also need emotional support. Establishing open channels of communication may also allow the family and carers to indicate if they need bereavement counselling or assistance at any stage.

Usually, the Being Open discussion and any investigation occur before the coroner’s inquest. The coroner’s report on post-mortem findings is a key source of information that will help to complete the picture of incidents leading up to the patient’s death. In any event an apology should be issued as soon as possible after the patient’s death, together with an explanation that the coroner’s process has been initiated and a realistic timeframe of when the family and carers will be provided with more information.

2. Children

The legal age of maturity for giving consent to treatment is 16. It is the age at which a young person acquires the full rights to make decisions about their own treatment and their right to confidentiality becomes vested in them rather than their parents or guardians. However, it is still considered good practice to encourage competent children to involve their families in decision making.

The courts have stated that younger children who understand fully what is involved in the proposed procedure can also give consent. This is sometimes known as Gillick competence or the Fraser guidelines. Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the Being Open process after a patient safety incident.

The opportunity for parents to be involved should still be provided unless the child expresses a wish for them not to be present. Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents alone or in the presence of the child. In these instances the parents’ views on the issue should be sought.

3. Patients with mental health issues
**Being Open** for patients with mental health issues should follow normal procedures, unless the patient also has cognitive impairment (see below). The only circumstances in which it is appropriate to withhold patient safety incident information from a mentally ill patient is when advised to do so by a consultant psychiatrist who feels it would cause adverse psychological harm to the patient. However, such circumstances are rare and a second opinion (by another consultant psychiatrist) would be needed to justify withholding information from the patient.

Apart from in exceptional circumstances, it is never appropriate to discuss patient safety incident information with a carer or relative without the express permission of the patient.

### 4. Patients with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them. They may have authorised a person to act on their behalf by an enduring Power of Attorney. In these cases steps must be taken to ensure this extends to decision making and to the medical care and treatment of the patient.

The **Being Open** discussion would be conducted with the holder of the power of attorney. Where there is no such person, the clinicians may act in the patient’s best interest in deciding who the appropriate person is to discuss incident information with, regarding the welfare of the patient as a whole and not simply their medical interests. However, the patient with a cognitive impairment should, where possible, be involved directly in communications about what has happened.

An advocate with appropriate skills should be available to the patient to assist in the communication process. See section 5 below

### 5. Patients with learning disabilities

Where a patient has difficulties in expressing their opinion verbally, an assessment should be made about whether they are also cognitively impaired (see section 4 above). If the patient is not cognitively impaired they should be supported in the **Being Open** process by alternative communication methods (i.e., given the opportunity to write questions down). An advocate, agreed on in consultation with the patient, should be appointed. Appropriate advocates may include carers, family or friends of the patient. The advocate should assist the patient during the **Being Open** process, focusing on ensuring that the patient’s views are considered and discussed.

### 6. Patients with different language or cultural considerations

The need for translation and advocacy services, and consideration of special cultural needs (such as for patients from cultures that make it difficult for a woman to talk to a male about intimate issues), must be taken into account when planning to discuss patient safety incident information. It would be worthwhile to obtain advice from an advocate or translator before the meeting on the most sensitive way to discuss the information. Avoid using ‘unofficial translators’ and/or the patient’s family or friends as they may distort information by editing what is communicated.

### 7. Patients with different communication needs

A number of patients will have particular communication difficulties, such as a hearing impairment. Plans for the meeting should fully consider these needs. Knowing how to enable or enhance communications with a patient is essential to facilitating an effective **Being Open** process. This involves focusing on the needs of
individuals and their families and being personally thoughtful and respectful.

8. Patients who do not agree with the information provided

Sometimes, despite the best efforts of healthcare staff or others, the relationship between the patient and/or their carers and the healthcare professional breaks down. They may not accept the information provided or may not wish to participate in the Being Open process. In this case the following strategies may assist:

• deal with the issue as soon as it emerges;
• where the patient agrees, ensure their carers are involved in discussions from the beginning;
• ensure the patient has access to support services;
• where the senior health professional is not aware of the relationship difficulties, provide mechanisms for communicating information, such as the patient expressing their concerns to other members of the clinical team;
• offer the patient, their family and their carers another contact person with whom they may feel more comfortable. This could be another member of the team or the individual with overall responsibility for clinical risk management;

• use a mutually acceptable mediator to help identify the issues between the healthcare organisation and the patient, and to look for a mutually agreeable solution;
• ensure the patient, their family and their carers are fully aware of the formal complaints procedures;

• Write a comprehensive list of the points that the patient, their family and their carers disagree with and reassure them you will follow up these issues.
APPENDIX 2 Draft Letter Template- following initial notification

Draft letter template following initial notification conversation with patient, family and/or carers following events resulting in harm. Please provide letter on WHHT headed paper and ensure that a copy is attached to the IR1.

Ref: Date
Dear Mr/Ms…,

Re: Investigation into (name patient and the issue under investigation)

Thank you for speaking to (name colleagues) and me this morning. We will be carrying out a detailed investigation to understand how (describe the issue under investigation). We have classed this as a (Serious Incident Requiring Investigation / Directorate Led Review / Investigation that will be led by the Departmental Manager… delete or amend as appropriate) because of (explain rationale for the investigation level). We are not yet clear if this could have been avoided, but will investigate this very carefully.

We are sincerely sorry that this has happened and for the distress that this has caused (name the patient) and your family. I would like to assure you that the Trust aims to provide a quality service to all our patients. The investigation will be led by (name yourself or the investigation lead). She/he has been selected because (explain the persons experience / reason for selecting them if this is relevant). I will support (name the lead investigator) with this investigation – delete sentence if you are the lead investigator.

We will need to take (insert the anticipated timescale for completing the investigation – X days or weeks if the specific end date is not known) to carry out this investigation. I appreciate that this might be frustrating, but we need to ensure that the investigation is done carefully.

We need to obtain information from a number of sources, including the staff who were involved on the day of the operation. (We will then meet with a multi-disciplinary team on the (RCA meeting date) to review the information that we collect, and the multi-disciplinary team will then draw their conclusions – delete if not carrying out a multi-disciplinary RCA).

We will be able to provide you with initial feedback after the (insert RCA meeting date), but we will not be able to provide you with a copy of the investigation report until this has been approved by our Trust Executive Team this may take a number of additional weeks. – Delete if not a SIRI or DLR
When we met you had the following questions to address with this investigation *(List questions that the family have for investigation / note that they did not have any at this stage).* If at any stage you do have any, please don’t hesitate to let me know. My contact details are on the top of this letter, and the ward staff / medical secretary / consultant *(delete or amend as is sensible for this case)* can also let me know that you would like to speak to me.

If you have any questions about the *(insert describe clinical outcome)*, then *(insert patient’s named consultant / clinical nurse specialist)* would be happy to discuss those questions with you. I would also like to assure that the fact that we are doing this investigation will in no way affect *(insert patient name)*’s ongoing care. I hope that you already knew this, but some families do worry.

You may also want to raise a formal complaint. We can respond to your questions without you raising a formal complaint, but I have included the details for how to do this in case you would like to.

I will aim to update you in three weeks’ time *(minimum time for first update, but reduce this if appropriate)*. Please do not hesitate to contact me in the meantime if you have any queries or concerns.

Yours sincerely cc

Patient’s consultant(s)
Ward Manager if an inpatient
Patient’s General Practitioner
Enc. Complaints leaflet
## APPENDIX 3  
Sources of support for patients, their families or carers

<table>
<thead>
<tr>
<th>External agencies</th>
<th>Details</th>
</tr>
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</table>
| **Bereavement Advice Centre**  
Helpline: 0800 634 9494  
http://www.bereavementadvice.org/ | Supports bereaved people on a range of practical issues via a single free phone number. It offers advice on all aspects of bereavement from registering the death and finding a funeral director through to probate, tax and benefit queries. |
| **British Association for Counselling and Psychotherapy**  
www.bacp.co.uk | The 'seeking a therapist' section of the website lists qualified counsellors and therapists by area. |
| **Child Bereavement Charity**  
Support and Information Line: 01494 446648  
http://www.childbereavement.org.uk | A national charity providing support to both bereaved families and the professionals who supporting them. |
| **Child Line**  
Helpline: 0800 1111  
| **Cruse Bereavement Care**  
Helpline: 0844 477 9400  
http://www.crusebereavementcare.org.uk | National charity providing information to anyone affected by a death. Exists to promote the well-being of bereaved people and to enable anyone bereaved by death to understand their grief and cope with their loss. Provides counselling and support and offers information, advice, education and training services. |
| **rd4u**  
Helpline: 0808 808 1677  
http://www.rd4u.org.uk | RD4U is a website designed for young people by young people. The youth branch of Cruse Bereavement Care to support people after the death of someone close. |
| **Royal College of Psychiatrists**  
http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/bereavement/bereavement.aspx | Information about how people normally grieve after a loss and places to get help. |
| **Samaritans**  
Helpline: 08457 90 90 90  
www.samaritans.org | 24 hour confidential emotional support for anyone in a crisis. |
| **Stillbirth and Neonatal Death Society (SANDS)**  
Helpline: 020 7436 5881  
http://www.uk-sands.org/ | A national charity, established by bereaved parents which aims to support anyone affected by the death of a baby. It works in partnership with health professionals to improve the quality of care and services offered to bereaved families and to promote research and changes in practice that could help to reduce the loss of babies lives. |
| **Support line**  
Helpline: 01708 765200  
http://www.supportline.org.uk | A helpline providing confidential emotional support to children, young adults and adults. |
Appendix 4  Draft Letter Template- following investigation

Draft letter template following investigation conclusion following events causing harm. Please provide letter on WHHT headed paper and ensure that a copy is attached to the IR1.

Ref:
Date
Dear Mr/Ms…,

Re: Investigation into (name patient and the issue under investigation)
I am writing to let you know that we have now concluded the investigation, into the (insert description of the incident) that affected (insert the patient’s name).

Either
As discussed earlier we have arranged to meet on (insert date & time) and the meeting has been planned to take place at (insert venue).
I will be accompanied at the meeting by (insert the name of any colleagues who are attending with you). You are welcome to bring a friend or family member along with you, but please let me know who this will be so that I can ensure that the meeting location is suitable.

Or
I would, therefore, like to invite you to contact me at your convenience on the above contact details, so that we can organise an appropriate day, time & venue should you wish to meet. I plan to be accompanied by (insert name of any accompanying colleagues) at the meeting. You are welcome to bring a friend or family member along with you, but please let me know who this will be so that I can ensure that the meeting location is suitable.

If however you do not wish to attend a meeting, I can arrange for the final report to be sent directly to you. We would prefer to meet with you to share the report as we are mindful that the fact that we refer to (insert patient’s name) as ‘the patient’ and use some technical language can make the report harder to read. Meeting to discuss the investigation conclusions would also allow us to clarify any queries that you have as they arise. You are though welcome to raise queries with us after that meeting if you prefer.
Finally, we at West Hertfordshire Hospital NHS Trust are very sorry for any suffering and distress caused as a result of this incident.

Either
I wish to assure you that we have learnt from the events surrounding (insert the patient’s name)’s care and have (delete as appropriate: agreed/ or are in the process of changing) (insert details of how we are changing our services / processes)
Or

I would like to assure you that we have carefully reviewed the care that we provided and have concluded that the (describe harm) was sadly unavoidable. At this stage we do not believe that it is appropriate for us to change the way that we work, but we will use the learning from this case to inform further service developments.

Yours sincerely cc RCA Chair if appropriate

Patient’s consultant(s)
Ward Manager if an inpatient
Patient’s General Practioner
## Communication Record
### Being Open

<table>
<thead>
<tr>
<th>Details Child/Baby's name</th>
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<tr>
<td>Mothers details</td>
<td></td>
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<tr>
<td>fathers details</td>
<td>DOB</td>
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<td>Contact details</td>
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<td>2</td>
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**Being Open Lead identified as:**

**Has the patient/family been informed?**

**Type of trust investigation:**

**Detail of information shared and by whom:**

**Date of first contact**

**Need for additional support**

**Detail of first meeting:**

**Venue:**

**Persons present:**

**Verbal apology given**

**Date of follow up letter**

<table>
<thead>
<tr>
<th>date</th>
<th>time</th>
<th>Content of meeting or discussion</th>
<th>Agreed actions</th>
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Ref: WHHT: G003  
Author: Danielle Boyd  
Date: October 2015  
Review Date: November 2017  
Version no: 2
<table>
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<tr>
<td>Information given:</td>
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<td>Questions asked by patient, family/carers</td>
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**Summary of last patient/family/carers contact and resolution**

**Please detail support needed/provided for staff:**

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<th>Date</th>
<th>time</th>
<th>Content of meeting or discussion.</th>
<th>Agreed actions</th>
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**Summary of last staff contact and resolution**

**Being Open**
## Patient Details

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| Address |  |

## Contact details

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<tr>
<th>Next of kin</th>
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<th>Relationship to patient</th>
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| Address |  |

## Being Open Lead identified as:

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| Has the patient/family been informed? |  |

<table>
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<tr>
<th>Date of incident</th>
<th>Datix number</th>
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## Need for additional support

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## Detail of first meeting:

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Summary of last patient/family/carers contact and resolution

Please detail support needed/provided for staff

Summary of last staff contact and resolution
A Summary of the Principles of Duty of Candour and Being Open.
A summary of the key actions of the NPSA’s Being Open Framework. This can be used in planning meetings with staff and patients following incidents, complaints or claims. Actions are grouped under the Ten Principles of Being Open.

1. Principle of acknowledgement
- Acknowledge and report all incidents, complaints promptly as per Incident Reporting Procedure and Complaints Policy and Procedure.
- Take seriously any reports of incidents/concerns from patients/carers.
- Take notice of a patient's concerns.

2. Principle of truthfulness, timeliness and clarity of communication
- Be truthful and give information in an open manner.
- Person giving information to be appropriately nominated.
- Give a step by step explanation of events.
- Timely communication – as soon as possible.
- Information to be based on known facts at the time.
- Explain that investigation may reveal more information.
- Tell patients how they will be updated on the progress of investigation.
- Provide a single point of contact for information, avoiding conflicting information from different staff.

3. Principle of apology
- Express sincere regret or sorrow as soon as possible and make an apology verbally and in writing. Written apology must clearly state the Trust is sorry for the suffering and distress caused.
- The most appropriate member of staff to make apology must be identified considering seniority, relationship to patient, experience and expertise regarding incident.

4. Principle of recognising patient and carer expectations
- Patients/carers expect a face-to-face meeting with representatives of the organisation.
- Maintain confidentiality.
- Identify names of people who can provide support to patient and whom patient has agreed can receive information e.g. PALs, a friend, Cruse Bereavement Care etc

Patient issues
- Identify any restrictions of openness the patient wants you to observe e.g. may not want to know all the details of what went wrong. In this case, respect wishes but say they can ask for full details later.
- Give several opportunities for patient/carer to gain information about incident.
- Provide verbal or written information. There is also the Trust Being Open leaflet available for patients.
- Develop ongoing care plan, tell patient/carers that care will be unaffected by any dispute.
- Take steps to make sure that carers etc are involved in discussions about incident, with patient's agreement.
• Provide access to information, observing confidentiality and patient instructions, to carers and those close to the patient. Information should assist decision making e.g. if patient cannot participate or has died.
• Ensure the patient understands the situation fully. Determine whether they need this information at different times.
• Provide carers with known information, care and support if a patient has died.
• Document discussions with patients/carers. Share information with them.
• Provide patients/carers with information on the complaints procedure and how to give positive or negative feedback to staff.
• Provide patients/carers with information on the incident reporting process.
• When appropriate, ensure the incident investigation e.g. through root cause analysis, includes the patient’s account of events leading up to the incident.
• Provide patients/carers with information on how improvement plans from root cause analysis will be implemented and monitored.

5. Principle of professional support

For staff
• Encourage reporting of incidents by all staff.
• Help staff feel supported throughout process as they may have been traumatised.
• Provide formal and informal debriefing of clinical team, separate from the requirement to provide statements for the investigation. Support your staff.
• Provide individual feedback on the final outcome of the investigation.
• Avoid disciplinary action and use the NPSA’s Incident Decision Tree if suspension considered.
• Provide advice and training on managing incidents.
• Provide information on support systems for staff distressed by incidents e.g. counselling, stress management, mentoring. Include staffs who lead discussions and the Being Open/Duty of Candour process.

For patients
• Discuss, assess and meet individual needs of patients/carers for practical and emotional help and support.
• Provide information on services offered by relevant support agencies and community services.
• Identify a staff member to provide timely, practical and emotional support, maintaining an ongoing relationship with the patient.
• Provide contact details to patient/carers.
• Provide the Trust leaflet explaining what to expect on the Being Open process.

6. Principle of risk management and system

Carry out Root Cause Analysis to uncover underlying causes of an incident.
• Focus on improving systems of care.
• Review the changes made to ensure they are effective.
• Share learning at 2 at the Top meetings, service area Clinical Governance Committees and in reports to the divisional governance committees.
• Serious risks should be entered on Divisional risk register.

7. Principle of multi-disciplinary responsibility
• Involve all staff who had key roles in patient’s care in root cause analysis and investigation.
• Communicate findings at multi-disciplinary meetings.
• Identify Being Open policy champions in all staff groups.

8. Principle of clinical governance
• Investigate and analyse incidents that are moderate, severe or lead to death.
• Identify clear accountabilities from Chief Executive, Board to all staff to ensure investigations, and action plans are implemented and the effectiveness of the process reviewed.
• Give information to health care staff on findings/learning from investigations.
• Audit the patient’s experience of Being Open. Monitor the implementation and effects of changes following an incident.

9. Principle of confidentiality
• Details of an incident are confidential.
• Seek consent of individual before disclosing information to others.
• Need to know basis for communications outside the clinical team.
• Anonymous records.
• Inform the patient/carers who will be undertaking the investigation before it takes place to allow them the opportunity to raise any objections.

10. Principle of continuity of care
• Continue giving patient all usual treatment, with compassion and respect.
• Make arrangements for alternative provision of care, if requested.

Ensure all Duty of Candour correspondence is documented and attached to Datix.
incident occurs

- Datix report immediately

moderate severe harm/death

- Duty of Candour applies.
- All other incidents causing harm, apologise and explain.
- (see appendix 6 for summary of Duty of Candour)

urgent team meeting

- Agree how disclosure discussion will occur with patient – urgent preliminary multi-team discussion.
- As soon as possible.

initial disclosure and apology

- DO NOT DELAY – As soon as possible; must be within 10 days of incident being reported to local systems (or sooner where possible)
- By Consultant/MDT/Ward Sister/Charge Nurse
- Face to face/verbal or letter (template see appendix 2)
- Disclosure, apology, information and support. Give outline of investigation. If a complaint and SI – complaint is handled through SI investigation process. Identify when/if patient would like to meet.

record communication

- Record communication in health records “Being Open – Duty of Candour” – Date, time, names present, issues, apology, plan for further communication. Save copy to Datix for evidence.
- if DoC has been declined by the family - this must be clearly documented.

maintain contact

- Maintain contact, as agreed with patient/family
- Perhaps a second meeting, telephone call etc.
- On approval of investigation report – letter and summary sent to patient/family. (see appendix 4)