

Duty of Candour and Being Open Policy and Procedure

Communicating Patient Safety Incidents with Patients and their Carers

Executive or Associate Director lead	Rachel Warner (Executive Medical Director)
Policy author / lead	Vin Lewin (Clinical Risk Manager)
Feedback on implementation to	Tania Baxter (Head of Integrated Governance)

Date of draft	November 2015
Dates of consultation period	January 2016 to February 2016
Date of ratification	14 April 2016
Ratified by	Executive Directors Group
Date of issue	2 September 2016
Date for review	31 March 2019

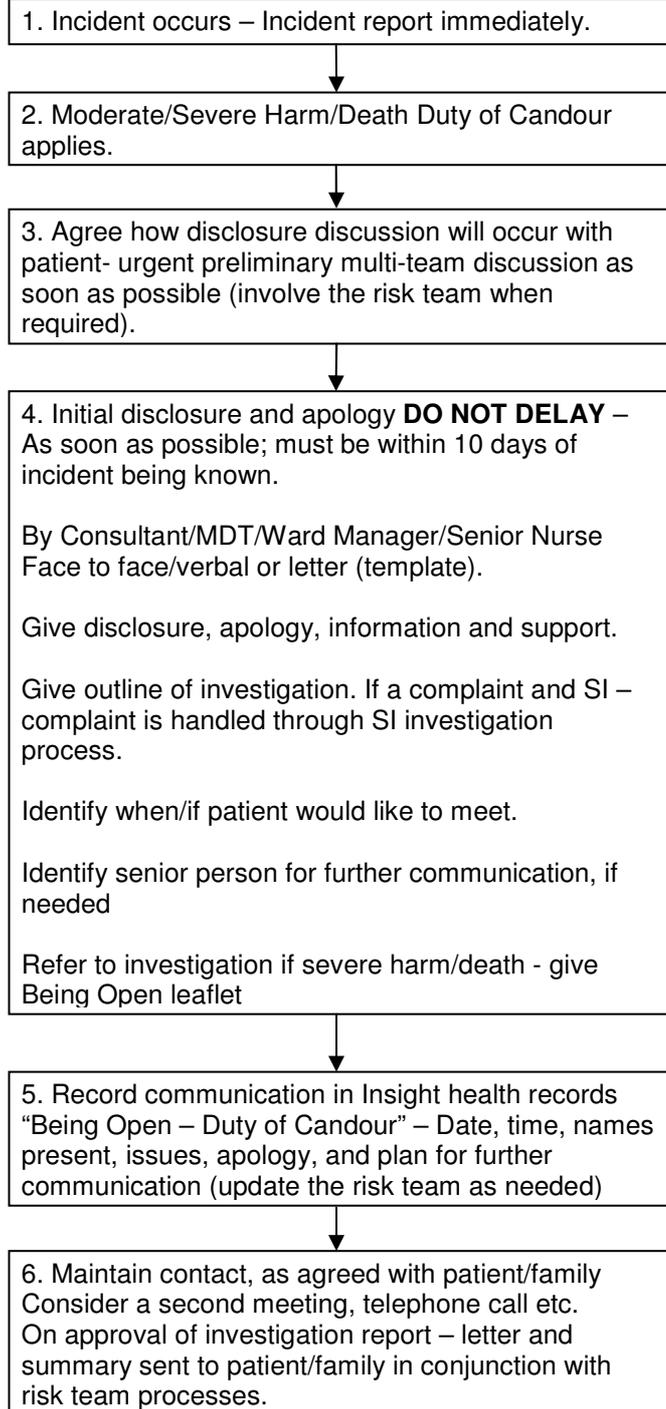
Target audience	All staff, clinical and non-clinical, particularly anyone involved in Being Open/Duty of Candour meetings e.g. Consultants, Clinical and Service Directors, Assistant Clinical Directors and Assistant Service Directors, Matrons and Ward Managers/Lead Nurses, Serious Incident investigators, Chief Executive and Directors, SUMEU, Complaints and Litigation Department and Risk Management Department, Clinical Governance, Patient Safety and Information Governance.
-----------------	---

<p>Policy Version and advice on document history, availability and storage</p> <p>This policy is available through the SHSC intranet.</p> <p>This is version 3 of this policy and replaces the first version issued in December 2008. The policy was reviewed in the light of an NPSA alert entitled “Being Open” and the Statutory Duty of Candour.</p>

Contents:

Section		Page
	Flow Chart of 'Duty of Candour' process	3
1	Introduction	4
2	Scope of this policy	5
3	Definitions	5
4	Purpose of this policy	6
5	Duties	6
6	Responsibility for this policy	6
7	Specific details	6
	7.1 Process and requirements	6
	7.2 Preliminary Team Discussion	7
	7.3 Choosing the individual best place to communicate with the service users and/or carers	7
	7.4 Preparation for the preliminary meeting with the service user and/or their carer	9
	7.5 Content of the preliminary meeting discussion	10
	7.6 Follow Up Meetings with Service users and/or Carers	11
	7.7 Completing the Process	12
8	Dissemination, storage and archiving	14
9	Training and other resource implications for this policy	14
10	Audit, monitoring and review	14
11	Implementation plan	15
12	Links to other policies, standards and legislation	15
13	Contact details	16
14	References	16
	Appendices:	
	Appendix A – Equality impact assessment form	17
	Appendix B – Human rights act assessment checklist	20
	Appendix C – Development and consultation process	22
	Appendix D Our Commitment	23
	Appendix E – The NPSA Ten Principles of Being Open	24
	Appendix F – NHSLA Leaflet 'Saying Sorry'	25/26

Duty of Candour Flow Diagram



1. Introduction

Candour and being open simply mean apologising and explaining what happened to service users and/or their carers who have been involved in a complaint or service user safety incident. A service user safety incident is defined as: '*any unintended or unexpected incident that could have or did lead to harm for one or more service users receiving NHS funded healthcare*' (NPSA 2005)

Communicating effectively with service users and/or their carers is a vital part of the process of dealing with errors or problems in their treatment. In doing so, NHS organisations can mitigate the trauma suffered by service users and potentially reduce lengthy formal complaints.

Candour and openness can also decrease the trauma felt by service users following a Service user Safety Incident or Complaint. Research has shown that service users fully support the Duty of Candour and Being Open and will forgive healthcare errors when they are disclosed promptly, fully and compassionately.

Candour and openness have benefits for healthcare staff. These include satisfaction that communication with service users and/or their carers has been handled in the most appropriate way; developing a good professional reputation for handling a difficult situation properly; and improving their understanding of incidents from the perspective of the service user and/or their carers. Candour and openness is also beneficial for the reputation of the Trust.

Setting the agenda for patient safety

Following the tragic events at Mid Staffordshire NHS Foundation Trust, the Patient Safety Domain has played a key role in taking forward the recommendations of the Francis Report, Berwick Report and Hard Truths, which set out the government's official response to the Francis Report.

A range of initiatives are underway to change the safety culture in the NHS to being one that is more open and honest, so we can learn from when things go wrong and take steps to prevent them from being repeated. These initiatives will ensure continual learning around safety improvement sits at the heart of the NHS, that the spread of successful safety improvement and best practice can be accelerated across the country, and that we are open and transparent through the publishing of patient safety data.

NHS England

NHS England is focused on safety and the continual reduction of avoidable harm, it supports organisations to become local learning systems with the ability to deliver high quality reliable healthcare. Systems centered on patients and devoted to learning have the freedom to evolve locally and become rooted in a culture relentlessly focused on safety at every level across the system.

National Health Service Litigation Authority (NHSLA)

The NHSLA is established to indemnify NHS Trusts in respect of both clinical negligence and non-clinical risks. It manages both claims and litigation and has established risk management programs against which NHS Trusts are assessed.

The promotion of good risk management and governance are integral components of the NHSLA schemes. There is now a single set of risk management standards for each type of NHS health care organisation: acute, ambulance, mental health and learning disability, and primary care trusts.

There are 3 levels, each with five standards and each of which has ten criterion; these standards cover different aspects of healthcare.

1. Governance
2. Competent and Capable Workforce
3. Safe Environment
4. Clinical Care
5. Learning from Experience

2. Scope of this policy

This policy is aimed at all healthcare staff responsible for ensuring the infrastructure is in place to support openness between healthcare professionals and service users and/or their carers following a complaint or an incident that led to moderate harm, severe harm or death.

It only relates to incidents or complaints that are classed as; Moderate (3), Major (4) or Catastrophic (5). It does not apply to Negligible (1) or Minor (2) incidents or complaints.

Description	Impact on individual
1. Negligible	No Injury
2. Minor	Short term injury / no permanent damage/harm. Will be resolved in about 1 month.
3. Moderate	Semi-permanent injury/damage (emotional, physical or psychological) likely to resolve within one year.
4. Major	Permanent injury (Physical or psychological)
5. Catastrophic	Unexpected or untoward death

3. Definitions

Complaint

A complaint is defined as an expression of dissatisfaction which requires a response whether it is verbally or in writing. Complaints may be about the activities of the Sheffield Health and Social Care Trust and/or its staff.

Incident

An incident is any unplanned event which causes injury to people, damage or loss to property or contributes to both including those involving medication, e.g., prescribing, dispensing, administration or storage of medicines and missing patients.

A Serious Incident is an accident/incident when a patient, staff or visitor suffers serious injury, major permanent harm or unexpected death (or the risk of death or injury) on Trust premises where healthcare is provided or where actions of health service staff are likely to cause significant public concern. (SHA Yorkshire and Humberside - April 2010).

Serious incidents includes adverse or critical clinical incidents where events or circumstances arising during NHS care could have, or did, lead to unintended or unexpected harm, loss or damage. (Harm is defined as physical or psychological injury, disease, suffering, disability or death. Normally, harm is considered to be 'unexpected' if it is not related to the natural course of the patient's illness or underlying condition). (Serious Incident Framework 2015)

4. Purpose of this policy

This Trust is committed to the principles of the Duty of Candour and being Open Policy and this policy details the meaning of the Duty and Openness in practice.

5. Duties

All staff working at SHSC should be aware of this policy and promote the principles and procedure of the Duty of Candour and Being Open when providing or supporting services.

All senior managers and in particular those staff investigating incidents or complaints must read and follow this policy. Staff in the risk management and complaints management teams will provide support and advice in the application of the policy.

Failure to adhere to the principles and requirements of the duty of candour may result in adverse publicity, legal proceedings and/or permanent damage to the reputation of the Trust.

Breaches of the statutory will be dealt with on a case by case basis but may lead to consideration of action against individuals under the disciplinary policy where wilful negligence of the principles of the statutory duty is identified.

6. Responsibility for this policy

The Deputy Chief Executive and Medical Director have overall responsibility for this policy assisted by a non-Executive Director who also sits on the Trust Quality and Risk group. The joint operational leads for the implementation of the Policy are the Head of Integrated Governance and the Trust Clinical Risk Manager.

7. Specific details

7.1 Process and requirements

The Duty of Candour and Being Open process begins with the recognition that a service user or staff member has suffered moderate or severe harm, or has died, as a result of a service user safety incident.

A face to face apology should be given immediately. Clinical staff may worry that being open with patients may compromise the ability to deal with a claim if one is subsequently made by the patient. In reality candour is all about sharing accurate information with

patients and should be encouraged. The facts are the facts and staff will be encouraged and supported to help patients understand what has happened to them.

Please refer to SHSC's Incident Reporting and Investigation Policy for details of how an incident should be identified, reported and managed (via Risk management and systems improvement techniques) or the Complaints Policy for how complaints should be handled. It is important that throughout the process, all communication relating to the incident or complaint is documented (details of the responsibilities relating to documentation can be found in the Trust's incident reporting, investigation and management policy).

7.2 Preliminary Team Discussion

The multidisciplinary team, including the most senior health professional involved in the complaint or service user safety incident, should meet as soon as possible after the event to:

- Establish the basic clinical and other facts;
- assess the complaint /incident to determine the level of immediate response;
- If the complaint or incident is rated as Moderate, Major or Catastrophic, the Duty of Candour and Being Open process will apply:
- Offer a face to face apology immediately and document this in the health care record
- identify who will be responsible for ongoing discussion with the service user and/or their carers
- Consider the appropriateness of engaging service user support at this early stage. This includes the use of a facilitator, a service user advocate or a healthcare professional who will be responsible for identifying the service user's needs and communicating them back to the healthcare team; where criminal cases are involved, obtain specialist advice from the Police/Crown Prosecution Service (CPS), however, where it is advised not to share information until a case is concluded, a letter/telephone contact should be considered by the appropriate Directorate lead to advise the service user or their carer that information will be shared and meetings facilitated as soon as possible following the Police investigation.
- Identify immediate support needs for the healthcare staff involved;
- Ensure there is a consistent approach by all team members around discussions with the service user and/or their carers;

Consider the timing of the *Duty of Candour* and *Being Open* discussion with the service user and/or carer. This meeting should happen as soon as possible after the complaint/incident is recognised but availability of key stakeholders and the clinical condition of the service user should be considered.

7.3 Choosing the individual best placed to communicate with the service users and/or carers, and who to communicate with

The healthcare professional who informs the service user and/or their carers about a service user safety incident should be the most senior person responsible for the service user's care and/or someone with experience and expertise in the type of incident that has

occurred. This could either be the service user's consultant, nurse consultant, or any other senior healthcare professional that has a designated caseload of service users. They should have received training in the communication of service user safety incidents

Consideration also needs to be given to the characteristics of the healthcare professional nominated to lead the *Duty of Candour / Being Open* process. They should:

- Be known to, and trusted by, the service user and/or their carers;
- Have a good grasp of the facts relevant to the complaint/incident;
- Be senior enough or have sufficient experience and expertise in relation to the type of service user safety incident to be credible to service users, carers and colleagues;
- Be able to commit to the time needed to complete the Duty of Candour and Being Open process;
- Have excellent interpersonal skills, including being able to communicate with service users and/or their carers in a way they can understand and avoiding any use of medical jargon;
- Be willing and able to offer an immediate face to face apology, reassurance and feedback to service users and/or their carers;
- Be able to maintain a medium to long term relationship with the service user and/or their carers, where possible, and to provide continued support and information;
- Be culturally aware and informed about the specific needs of the service user and/ or their carers.
- Be mindful that service users and carers may require additional support i.e. professional services, support groups etc and how to access these

Junior staff (or those in training) should not lead the *Duty of Candour / Being Open* process, but may attend as an observer for training purposes with the explicit and informed consent of the service user and/or carer.

There should always be communication with the service user unless there are strong clinical reasons not to do so, for example if the service user is too unwell at the time. In the event of the death of a service user, communication should normally be with the 'relevant person', CQC regulation 20 defines this as 'the person acting lawfully on their behalf following the death of the patient'. The clinical team will need to decide who this should be from their knowledge of the service user's family circumstances and any pre-determined legally binding agreements. In addition to this where the patient is 16 or over and lacks the mental capacity in relation to the matter appropriate steps should be taken in accordance with the Mental Capacity Act 2005 to determine who the most appropriate person is to communicate with.

It is essential practice to include communication with close family members or carers as well as the service user affected by a serious incident or complaint. However, the views of the service user about confidentiality and whether to involve family members should be taken into account in deciding who to contact.

The decision about who to contact must be recorded. If it is decided not to contact either the service user or carer, the reason for not contacting them must be recorded. This will form part of the incident or complaint investigation record.

Involving healthcare staff who make mistakes

Some service user safety incidents that resulted in moderate harm, severe harm or death will result from errors made by healthcare staff while caring for the service user. In these circumstances the member(s) of staff involved may or may not wish to participate in the *Duty of Candour / Being Open* discussion with the service user and/or their carers. Every case where an error has occurred needs to be considered individually, balancing the needs of the service user and/or their carers with those of the healthcare professional concerned. In cases where the healthcare professional who has made an error wishes to attend the discussion to apologise personally, they should feel supported by their colleagues throughout the meeting. In cases where the service user and / or their carers express a preference for the healthcare professional not to be present, it is advised that a personal written apology is handed to the service user and/or their carers during the first *Duty of Candour / Being open* discussion.

7.4 Preparation for the preliminary meeting with the service user and/or their carer

Who should attend?

- The senior SHSC staff member who has been chosen to lead the Duty of Candour / Being open process
- The person taking the lead should be supported by at least one other member of staff, such as the clinical risk manager, complaints manager, nursing or medical director or member of the healthcare team treating the service user.
- Ask the service user and/or their carers who they would like to be present
- Hold a pre-meeting amongst healthcare professionals so that everyone knows the facts and understands the aims of the meeting

When should it be held?

- Within 10 days of the complaint/incident being known
- Consider the service user's and/or their carer's home and social circumstances
- Check they are happy with the timing
- Offer them a choice of date/times and confirm the chosen date/time in writing
- Do not cancel the meeting unless it is absolutely necessary

Where should it be held?

- Use a quiet room where you will not be distracted by work or interrupted
- Do not host the meeting near to the place where the incident occurred if this is difficult for the service user and/or their carers
- Offer to meet at the service user's home if this is most suitable for them

What should be prepared in advance of the meeting?

- Investigate possible sources of support and counselling that you anticipate the service user and /or carer may need as a result of the incident or complaint.
- Investigate the needs of service users with special circumstances, for example, linguistic or cultural needs, and those with learning disabilities or cognitive impairment. SHSC has access to spoken language interpreters, British Sign Language interpreters for hearing impaired

service users, and Deaf-Blind Communication Support Workers. The SHSC Service User Engagement team (SUMEU) should be able to help you organise this

How should you approach the service user and/or their carers?

- Speak to the service user and/or their carers as you would want someone in the same situation to communicate with you or your own family
- Do not use jargon or acronyms: use clear, straightforward language
- Consider the needs of service users with special circumstances, for example linguistic or cultural needs, people with cognitive impairment, learning disabilities and people with sensory needs.

7.5 Content of the preliminary meeting discussion

What should be discussed?

- The service user and/or their carers should be advised of the identity and role of all people attending the *Duty of Candour / Being Open* discussion before it takes place. This allows them the opportunity to state their own preferences about which healthcare staff should be present.
- All incidents should be acknowledged within 10 days of the incident being known.
- There should be an expression of genuine sympathy, regret and an immediate apology for the harm that has occurred.
- All communication should be truthful, timely, clear and confidential.
- The facts that are known are agreed by the multidisciplinary team. Where there is disagreement, communication about these events should be deferred until after the investigation has been completed. The service user and/or their carers should be informed that an investigation is being carried out and more information will become available as it progresses.
- It should be made clear to the service user and/or their carers that new facts may emerge as the complaints/incident investigation proceeds.
- The service user's and / or carer's understanding of what happened should be taken into consideration, as well as any questions they may have.
- There should be consideration and formal noting of the service user's and/or carer's views and concerns, and demonstration that these are being heard and taken seriously.
- Appropriate language and terminology should be used when speaking to service users and/or their carers. For example, using the terms 'service user safety incident' or 'adverse event' may be at best meaningless and at worst insulting to a service user and/or their carers. If a service user's and/or their carer's mother tongue is not English, it is also important to consider their language needs – if they would like the *Duty of Candour / Being open* discussion conducted another language this should be arranged.
- An explanation should be given about what will happen next in terms of the long term treatment plan and incident findings.
- Information on likely short and long term effects of the incident (if known) should be shared. The latter may have to be delayed to a subsequent meeting when the situation becomes clearer.

- An offer of practical and emotional support should be made to the service user and/or their carers. This may involve getting additional help from third party professional support, such as charities and voluntary organisations as well as offering more direct assistance. Information about the service user and the incident should not normally be disclosed to third parties without consent.
- It should be recognised that service users and/or their carers may be anxious, angry and frustrated even when the *Duty of Candour / Being Open* discussion is conducted appropriately.
- Contact details for the healthcare professional leading the Duty of Candour / Being Open process should be given to the service user and/or carer.

It is essential that the following does not occur:

- Speculation;
- Attribution of blame;
- Denial of responsibility;
- Provision of conflicting information from different individuals.

The initial *Duty of Candour / Being Open* discussion is the first part of an ongoing communication process. Many of the points raised here should be expanded on in subsequent meetings with the service user and/or their carers.

What should be documented?

The following should be documented and passed to the Clinical Risk Manager or Complaints Manager (as appropriate) once the *Duty of Candour / Being Open* meeting is complete:

- The time, place, date, as well as the name and relationships of all attendees
- The plan for providing further information to the service user and/or their relative / carers
- Offers of assistance and the service user's and/or their relative / carer's response
- Questions raised by the family and / or carers or their representatives, and the answers given
- Plans for follow-up as discussed
- Progress notes relating to the clinical situation and an accurate summary of all the points explained to the service user and/or their relative / carers
- Copies of letters sent to the GP for service user safety incidents not occurring within primary care
- Copies of any statements taken in relation to the service user safety incident or complaint
- A copy of the incident report or complaint letter. Full minutes of the Duty of Candour / *Being Open* discussion meeting, which should be signed and dated by the Chair and all members of the panel present, should be shared with the service user and/or their relative / carer

Clarify in writing the information given; reiterate key points, record action points and assign responsibilities and deadlines

7.6 Follow up meetings with service users and/or carers

The Duty of Candour and Being Open is not a one off event and regular follow up meetings should be arranged by the investigation lead to ensure that staff, the service user or service user and/or relative / carers are kept updated

- Clarify in writing the information given, reiterate key points, record action points and assign responsibilities and deadlines
- The service user's notes should contain a complete, accurate record of the discussion(s) including the date and time of each entry, what the service user and / or their carers have been told and a summary of agreed action points
- Maintain a dialogue by addressing any new concerns, share new information once available and provide information on counseling, as appropriate
- Try to include the service user and carer in generating solutions to any problems identified through the investigation.
- Consideration should be given to the timing of meeting, based on both the service user's health and personal circumstances.
- Consideration should be given to the location of the meeting e.g. the service user's home.
- Feedback should be given on progress to date and information provided on the investigation process.
- There should be no speculation or attribution of blame. Similarly, the healthcare professional communicating the incident must not criticise or comment on matters outside their own experience.
- The service user and/or their carers should be offered an opportunity to discuss the situation with another relevant professional where appropriate.
- Patients are entitled to expect that they will continue to receive all usual treatment and continue to be treated with dignity, respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made for them to receive treatment elsewhere.
- A written record of the discussion should be kept and shared with the service user and/or their carers (see 7.5 for details of documentation recommended).
- All queries should be responded to appropriately.
- If completing the process at this point, the service user and / or their carers should be asked if they are satisfied with the investigation and a note of this made in the service user's records.
- The service user should be provided with contact details so that if further issues arise later there is a conduit back to the relevant healthcare professionals or an agreed substitute.

7.7 Completing the Process

Communication with the service user and/or their carers

After completion of the complaint/incident investigation, feedback should take the form most acceptable to the service user. Whatever method is used, the communication should include:

- The chronology of clinical and other relevant facts;
- Details of the service user's and/or their carer's concerns and complaints;

- A repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the service user safety incident;
- A summary of the factors that contributed to the incident;
- Information on what has been and will be done to avoid recurrence of the incident and how these improvements will be monitored.

It is expected that in most cases there will be a complete discussion of the findings of the investigation and analysis. In some cases information may be withheld or restricted, for example, where communicating information will adversely affect the health of the service user; where investigations are pending coronial processes; or where specific legal requirements preclude disclosure for specific purposes. In these cases the service user will be informed of the reasons for the restrictions.

Continuity of care

When a service user has been harmed during the course of treatment and requires further therapeutic management or rehabilitation, they should be informed, in an accessible way, of the ongoing clinical management plan. This may be encompassed in discharge planning processes addressed to designated individuals such as the referring GP when the service user safety incident has not occurred in primary care.

Service users and / or their carers 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 that they have the right to continue their treatment elsewhere if they have lost confidence in the healthcare team involved in the service user safety incident.

Communication with the GP and other community care service providers for service user safety incidents not occurring in primary care

Wherever possible, it is advisable to send a brief communication to the service user's GP, before discharge, describing what happened.

When the service user leaves the care of the Trust, a discharge letter should also be forwarded to the GP or appropriate community care service. It should contain summary details of:

- The nature of the service user safety incident and the continuing care and treatment
- The current condition of the service user
- Key investigations that have been carried out to establish the service user's clinical condition
- Recent results
- Prognosis.

It may be valuable to consider including the GP in one of the follow-up discussions either at discharge or at a later stage.

Monitoring and compliance

Any recommendations for systems improvements and changes implemented should be monitored for effectiveness in preventing a recurrence. The investigation report will include recommendations and an action plan together with lead roles for implementing any changes agreed and timescales. Progress on the action plan will be followed up by the senior leadership team of the directorate concerned and the Trusts Service User Safety Group. Continuing feedback on progress on action plans to the service user and / or carer

should be agreed as part of the action plan, in response to what the service user and/or carer wants to know.

Communication of changes to staff

Effective communication with staff is a vital step in ensuring that recommended changes are fully implemented and monitored. It will also facilitate the move towards increased awareness of service user safety issues and the value of the Duty of Candour and being open.

8. Dissemination, storage and archiving

This policy will be posted on the Sheffield Health and Social Care Trust intranet website and available to all staff within 7 days of its ratification. There will be a link to the policy on the homepage of the intranet website.

An 'All SHSC staff' email alert will be sent to all staff, informing them of this new policy. In addition Clinical, Service and Support Directors will be instructed to ensure that all teams and areas are made aware of this policy and how to apply it.

A web link or copy will be sent to any members of staff that investigate an incident or a complaint by the risk management or complaints team.

The Integrated Governance team will keep a paper and an electronic version of the previous guidance for archive purposes. Please contact them if a copy is needed.

9. Training and other resource implications for this policy

All staff should be made aware of the Duty of Candour and Being Open policy. This will be done through the Trust's usual communication systems when a policy has been developed / reviewed. New staff will be made aware of the policy through induction processes.

Staff who are responsible for incident, complaint and claims management can receive advice and support on this policy through the Trust's Head of Integrated Governance, Clinical Risk Manager and the Complaints and Litigation Lead.

10. Audit, monitoring and review

This policy must also be compliant with the Risk Management standards. The implementation of this policy and its effectiveness, or lack of effectiveness will be monitored by the Head of Integrated Governance, on behalf of the Quality Assurance Committee.

Risk Management Standards - Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual / group / committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual / group / committee for action plan monitoring and implementation
How communication is encouraged	Review of incident investigation reports	Risk Management Department	6 monthly	Service User Safety Group	Service User Safety Group	Service User Safety Group

How staff acknowledge apologise and explain when things go wrong	Review of incident investigation reports	Risk Management Department	6 monthly	Service User Safety Group	Service User Safety Group	Service User Safety Group
Requirements for truthfulness, timelines and clarity of communication	Review of incident investigation reports	Risk Management Department	6 monthly	Service User Safety Group	Service User Safety Group	Service User Safety Group
How additional support is provided	Review of incident investigation reports	Risk Management Department	6 monthly	Service User Safety Group	Service User Safety Group	Service User Safety Group
How communication is recorded	Review of incident investigation reports	Risk Management Department	6 monthly	Service User Safety Group	Service User Safety Group	Service User Safety Group

This policy will be reviewed in 3 years time. Further audit, monitoring and review will be agreed at that point.

11. Implementation plan

Action / Task	Responsible Person	Deadline	Progress update
Dissemination, storage and archiving	Post on Trust intranet	April 2016	Issued 02.09.2016
	'All SHSC staff' email alert	June 2016	Communications Digest w/e 11.09.2016
	OMG email alert to directors	April 2016	Clinical Directors 02.09.2016
	Team managers to ensure all staff have access to latest version of this policy, and the previous guidance is removed and destroyed	April 2016	30.09.2016
Training and development	Amend induction programme for all staff and for new managers	May 2016	Email sent to training team on 02.09.2016
	Training for Duty of Candour and Being Open discussion leads	Ongoing from April 2015	Email sent to training team on 02.09.2016
New roles and responsibilities	Clinical audit programme to include audit of implementation of this policy	2015 onwards	No change.

12. Links to Other Policies

This policy should be read in conjunction with SHSC Complaints Procedure, Claims Policy, SHSC Incident Management Policy and Human Resources Disciplinary Policy.

13. Contact details

Title	Name	Phone	Email
Head of Integrated Governance	Tania Baxter	27163279	tania.baxter@shsc.nhs.uk
Complaints and Litigation Lead	Wendy Hedland	2718956	wendy.hedland@shsc.nhs.uk
Clinical Risk Manager	Vin Lewin	27 16379	vin.lewin@shsc.nhs.uk

14. References

1. NHSLA (2010)
Risk management Standards for Mental Health and Learning Disability Trusts
www.nhsla.com/publications (click on risk management link)
2. National Patient Safety Agency (2009)
'Being Open' – saying sorry when things go wrong; communicating patient safety incidents with patients and carers
NPSA London
- 3 NHSLA guidance 2014 'The Duty of Candour' Guidance
- 4 *CQC- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20*

Appendix A Equality impact assessment form

	Negative Impact - It could potentially Disadvantage	Positive Impact - It could potentially Advantage	Reason / Evidence
RACE	Yes		Different format or explanation of content would need to be provided and further explanations and support to understand the policy.
GENDER			This policy has no impact with relation to gender
DISABILITY	Yes		Different format or explanation of content would need to be provided and further explanations and support to understand the policy.
The Disability Discrimination Act 1995 defines disability as <i>'a physical or mental impairment which has a substantial and long-term effect on a person's ability to carry out normal day-to-day activities'</i> .			
SEXUAL ORIENTATION			This policy has no impact with relation to sexual orientation
AGE			This policy has no impact with relation to age
RELIGION OR BELIEF			This policy has no impact with relation to religion or belief

If you have identified that there may be a negative impact for any of the groups above, is the **negative** impact...

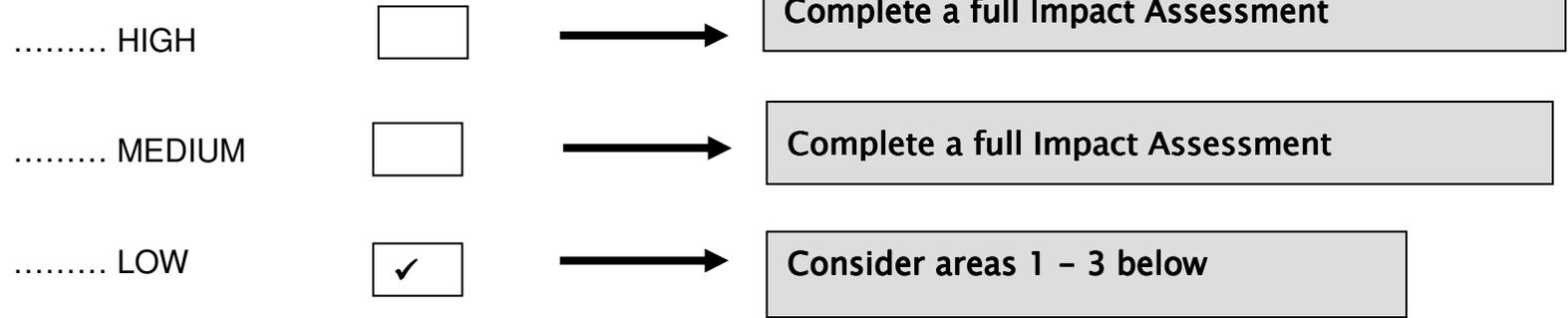
INTENDED? YES No

LEGAL? YES No Don't know →

Take legal advice and address legality of the policy

(I.e. does it breach antidiscrimination legislation either directly or indirectly?)

Level of Impact



1. Can the low negative impact be removed?

Yes, by the provision of appropriate translations and supporting material for people with languages other than English as their first language, sensory impairment or learning disabilities.

If you have not identified a negative impact

2. Can any Positive impact be improved?

n/a

3. If there is no evidence that the policy promotes equality and equal opportunity or improves relations with any of the above groups, could the policy be developed or changed so that it does?

n/a

Having considered the assessment, is any specific action required - Please outline this using the pro forma action plan below
(The lead for the policy is responsible for putting mechanisms in place to ensure that the proposed action is undertaken)

None required

STAGE 1 COMPLETED BY

SIGNATURE

Stage 1 EQIA received by Service User Engagement and Equality Teams

Stage 1 outcome agreed.

Signed

(Head of Service User Engagement and Equality Teams)

Stage 1 Outcome needs review (Details)

Returned to lead (Date)

Signed

If a full EQIA is required the stage 1 assessment form should be retained and a completed EQIA report submitted to the relevant governance group for agreement by the chair. The chair will forward the completed reports to the Service user Experience and Equality team for publication.

Appendix B - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a persons Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site <http://www.sct.nhs.uk/humanrights-273.asp> (relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. Is your policy based on and in line with the current law (including case law) or policy?

- Yes. No further action needed.**
- No. Work through the flow diagram over the page and then answer questions 2 and 3 below.**

2. On completion of flow diagram – is further action needed?

- No, no further action needed.**
- Yes, go to question 3**

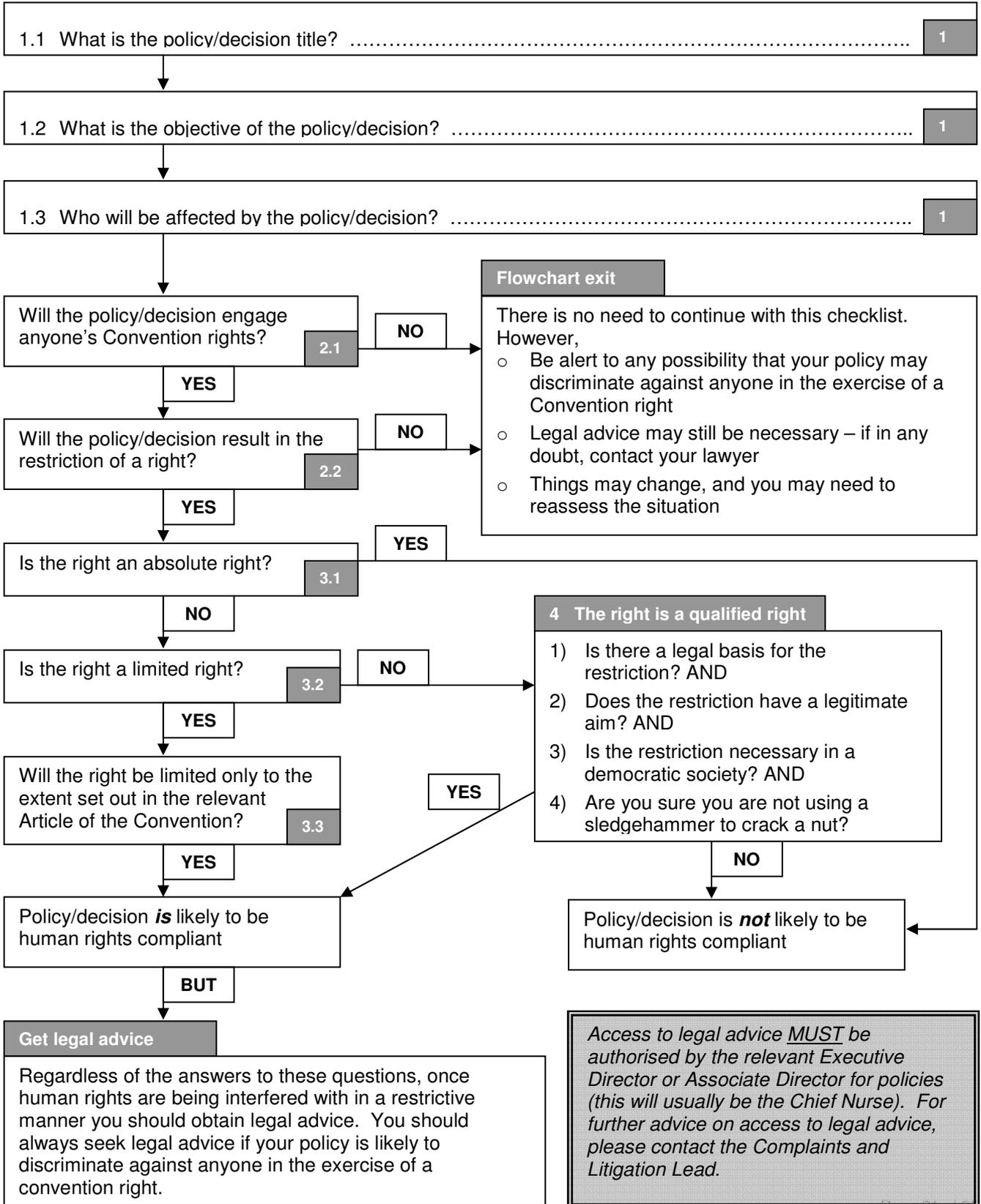
3. Complete the table below to provide details of the actions required

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose 'Format Text Box' and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.



Appendix C - Development and consultation process

The Head of Integrated Governance led the development of this new policy. A draft was circulated to the individuals below for comments in January 2016.

- Head of Integrated Governance
- Risk Management team
- Heads of Service User Engagement
- Professional Lead Nurse's
- CMHT teams
- Woodland View Nursing home
- Internal Audit (shared as part of the recent internal audit)

Appendix D

Our Commitment

Being Open with our Service Users and Carers

Our Commitment

Staff work hard to deliver the highest standards of healthcare to all service users at Sheffield Health and Social Care NHS Foundation Trust. We provide safe and effective care to many thousands of people every year but sometimes, despite our best efforts, things can and do go wrong.

If a service user is harmed as a result of a mistake or error in their care, we believe that they, their family or those who care for them, should receive an apology, be kept fully informed as to what has happened, have their questions answered and know what is being done in response. This is something that we call *Being open* and we make a commitment to our service users to:

- acknowledgement of the incident
- apologise for the harm caused
- explain, openly and honestly, what has gone wrong
- describe what we are doing in response to the mistake
- offer support and counseling services that might be able to help
- provide the name of a person to speak to
- give updates on the results of any investigation

Kevan Taylor

Chief Executive, Sheffield Health and Social Care NHS Foundation Trust

Appendix E

The Ten Principles of Being Open

1. Principle of acknowledgement

All service user safety incidents should be acknowledged and reported as soon as they are identified. In cases where the service user and/or their carers inform healthcare staff when something has happened, their concerns must be taken seriously and should be treated with compassion and understanding by all staff. Denial of a person's concerns will make future open and honest communication more difficult.

2. Principle of truthfulness, timeliness and clarity of communication

Information about a service user safety incident must be given in a truthful and open manner by an appropriately nominated person. Communication should also be timely informing the service user and/or their carers what has happened as soon as is practicable, based solely on the facts known at that time. Explain that new information may emerge as an incident investigation takes place and that they will be kept up to date. Service users and/or their carers should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have.

3. Principle of apology

Service users and/or their carers should receive a sincere expression of sorrow or regret for the harm that has resulted from a service user safety incident. This should be in the form of an appropriately worded agreed manner of apology, as early as possible. Verbal apologies are essential because they allow face to face contact. A written apology, which clearly states the organisation is sorry for the suffering and distress resulting from the incident, must also be given. Both verbal and written apologies should be given. Saying sorry is not an admission of liability and it is the right thing to do.

4. Principle of recognising service user and carer expectations

Service users and/or their carers can reasonably expect to be fully informed of the issues surrounding a service user safety incident, and its consequences, in a face to face meeting with representatives from the Trust. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times. Service users and/or their carers should also be provided with support in a manner to meet their needs. This may involve an independent advocate or an interpreter. Information on the Service user Engagement Service and other relevant support groups should be given as soon as possible.

5. Principle of professional support

The Trust must create an environment in which all staff are encouraged to report service user safety incidents. Staff should feel supported throughout the incident investigation process; they too may have been traumatised by the incident. To ensure a robust and consistent approach to incident investigation the NHS has developed an Incident Decision Tree (ICT). Where there is reason for the Trust to believe a member of staff has committed a punitive or criminal act, the organisation should take steps to preserve it's position and advise the member(s) of staff at an early stage to enable them to obtain separate legal advice and/or representation. Staff should be encouraged to seek support from relevant professional bodies.

6. Principle of risk management and systems improvement

Root cause analysis (RCA) or similar techniques should be used to uncover the underlying causes of a service user safety incident. Investigation should focus on improving systems of care, which will be reviewed for their effectiveness.

7. Principles of multi-disciplinary responsibility

The Duty of Candour and Being Open Policy applies to all staff who have roles in direct and indirect service user care. Most healthcare provision involves multi-disciplinary teams and communication with service users and/or their carers following an incident that led to harm should reflect this. This will ensure that the Duty of Candour and Being Open process is consistent with the philosophy that incidents usually result from system failures and rarely from the actions of an individual. To ensure multidisciplinary involvement in the process, it is important to identify clinical, nursing and managerial leaders who will champion it. Both senior managers and senior clinicians must participate in the incident investigation and clinical risk management.

8. Principles of clinical governance

Being Open requires the support of service user safety and quality improvement through clinical governance frameworks, in which service user safety incidents are investigated and analysed, to find out what can be done to prevent their recurrence. It also involves a system of accountability through the chief executive to the board to ensure these changes are implemented and their effectiveness reviewed. These findings should be disseminated to staff so they can learn from service user safety incidents. Audits should be developed to monitor the implementation and effects of changes in practice following a service user safety incident.

9. Principle of confidentiality

Details of a service user safety incident should at all times be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the service user. Where this is not practicable or an individual refuses consent to the disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the incident have statutory powers for obtaining information.

Communications with parties outside of the clinical team should be anonymous when used for the purposes of wider learning (Information for the police or the coroner should be discussed with the appropriate corporate lead). It is good practice to inform the service user and/or their carers about who will be involved in the investigation before it takes place, and give them the opportunity to raise any objections and be involved.

10. Principle of continuity of care

Service users are entitled to expect they will continue to receive all usual treatment and continue to be treated with respect and compassion. If a service user expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made for them to receive treatment elsewhere.

Appendix F – NHSLA Leaflet ‘Saying Sorry’ (Continued overleaf)

Saying Sorry

Saying sorry when things go wrong is vital for the patient, their family and carers, as well as to support learning and improve safety. Of those that have suffered harm as a result of their healthcare, fifty percent wanted an apology and explanation. Patients, their families and carers should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm that has occurred.

Warning
from claims

Resolving
disputes fairly

Professional
advice

Encouraging
safer care

Protecting
NHS resources

Learning
for

Warning
for care

Resolving
disputes fairly

Professional
advice

Protecting
NHS resources

How should this happen?

Verbal apologies are essential because they allow face-to-face contact between the patient, their family and carers and the healthcare team. This should be given as soon as staff are aware an incident has occurred. A written apology, which clearly states the healthcare organisation is sorry for the suffering and distress resulting from the incident, must also be given.

Who should say sorry?

Information about a patient safety incident must be given to patients and their families in a truthful and open manner by an appropriately nominated person. Staff may be unclear about who should talk to patients when things go wrong and what they should say; there is the fear that they might upset the patient, say the wrong things, make the situation worse and admit liability. Having a local policy that sets out the process of communication with patients and raising awareness about this will provide staff with the confidence to communicate effectively. The local policy should state who is the most appropriate

member of staff to give both verbal and written apologies to patients and their families; the decision should consider seniority, relationship to the patient, experience and expertise. Most healthcare provision is through multidisciplinary teams so any local policy on openness should apply to all staff that have key roles in the patient's care.

What if there is a formal complaint or claim?

Poor communication may make it more likely that the patient will pursue a complaint or claim. It is important not to delay giving a meaningful apology for any reason, including where there is a formal complaint or claim. It is also essential that any information given is based solely on the facts known at the time. Healthcare professionals should explain that new information may emerge as an investigation is undertaken, and that patients, their families and carers will be kept up-to-date with the progress of an investigation.

Is an apology the same as an admission of liability?

Saying sorry is not an admission of legal liability; it is the right thing to do. The NHS LA is not an insurer and we will never withhold cover for a claim because an apology or explanation has been given. The NHS LA claims teams are always happy to provide support and advice where there is a potential claim.

What about the staff involved?

Healthcare organisations must create an environment in which all staff, whether directly employed or independent contractors of NHS care, are encouraged to report patient safety incidents. Staff should feel supported throughout the investigation process because they too may have been traumatised by being involved. Sometimes patients can suffer significant harm. In these circumstances, the member(s) of staff involved may find it hard to participate in the discussion with the patient and their family. Every case needs to be considered individually, balancing the needs of the patient

and their family with those of the healthcare professional concerned. In cases where the healthcare professional responsible wishes to attend the discussion to apologise personally, they should feel supported by their colleagues throughout the meeting. In cases where the patient and their family express a preference for the healthcare professional not to be present, it is advised that a personal written apology is handed to the patient, their family and carers during the initial Being Open discussion.

For more information

Being Open Guidance (National Patient Safety Agency)

www.nrls.npsa.nhs.uk

Reports and Consultations on complaint handling (Parliamentary and Health Service Ombudsman)

www.ombudsman.org.uk

Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture (Clwyd and Hart)

www.gov.uk

Key messages

Timeliness: The initial discussion with the patient and their family should occur as soon as possible after recognition that something has gone wrong.

Explanation: Patients and their families should be provided with a step-by-step explanation of what happened, that considers their individual needs and is delivered openly.

Information: Patients and their families should receive clear, unambiguous information. They should not receive conflicting information from different members of staff. The use of medical jargon and acronyms, which they may not understand, should be avoided.

On-going support: Patients and their families should be given a single point of contact for any questions or requests they may have. They should also be provided with support in a manner appropriate to their needs. This involves consideration of special circumstances that can include a patient requiring additional support, such as an independent patient advocate or a translator.

Confidentiality: Policies and procedures should give full consideration of, and respect for privacy and confidentiality for the patient, their family and staff.

Continuity of care: Patients are entitled to expect that they will continue to receive all usual treatment and continue to be treated with dignity, respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made for them to receive treatment elsewhere.

“Achieving timely and fair resolution, enhancing learning and improving safety.”