Sherwood Forest Hospitals NHS
NHS Foundation Trust

Title: Being Open Policy- a Duty to be Candid Communicating care and treatment related harm with patients, their families and carers				
Date Approved: dd-mm-yyyy	**Approved by:** Board of Directors	**Date of review:** October 2016	**Policy Ref:** G/BOP-01	**Issue:** 4.0
Division/Department: Governance Support Unit		**Policy Category:** Governance		
Author (post-holder): Head of Governance		**Sponsor (Director):** Executive Medical Director Executive Director of Nursing & Quality		

CONTENTS

Amendments

Issue	Issue Date	Section(s) involved	Amendment
4.0	15-10 -2014	• All	• Full review and re-write

Executive Summary

The effects on patients, relatives, carers and staff, when things go wrong, can be devastating. 'Being Open - a duty to be candid' outlines the principles that healthcare staff should use when communicating with patients, their families and carers following a notifiable safety incident, complaint or claim (hereafter referred to as 'event') where a patient was harmed. It supports a culture of openness, honesty and transparency[1]. This policy incorporates the 'Duty of Candour' which was made a contractual obligation in April 2013 and reinforces the fundamental obligation to be open and honest in the event of an incident where patient harm has occurred. The 'Duty of Candour' has also been written into the latest revision of the NHS Constitution[2].

This policy addresses Sherwood Forest Hospitals NHS Foundation Trust's (The Trust) response to the ethical responsibility and duty of candour when a patient safety incident occurs, using the 10 principles underpinning 'Being Open' as supported by the National Patient Safety Agency (NPSA). These are:

- Acknowledgement
- Truthfulness, timeliness and clarity of communication
- Apology
- Recognising patient and carer expectation
- Professional support
- Patient Safety, Risk Management and systems improvement
- Multidisciplinary responsibility
- Clinical governance
- Confidentiality
- Continuity of care

From October 2014 NHS providers are required to comply with the statutory duty of candour. Meaning providers must be open and transparent with service users about their care and treatment, including when it goes wrong. The duty of candour will require all health and adult social care providers registered with CQC to be open with people when things go wrong. The regulations impose a specific and detailed duty of candour on all providers where any harm to a service user from their care or treatment is above a certain

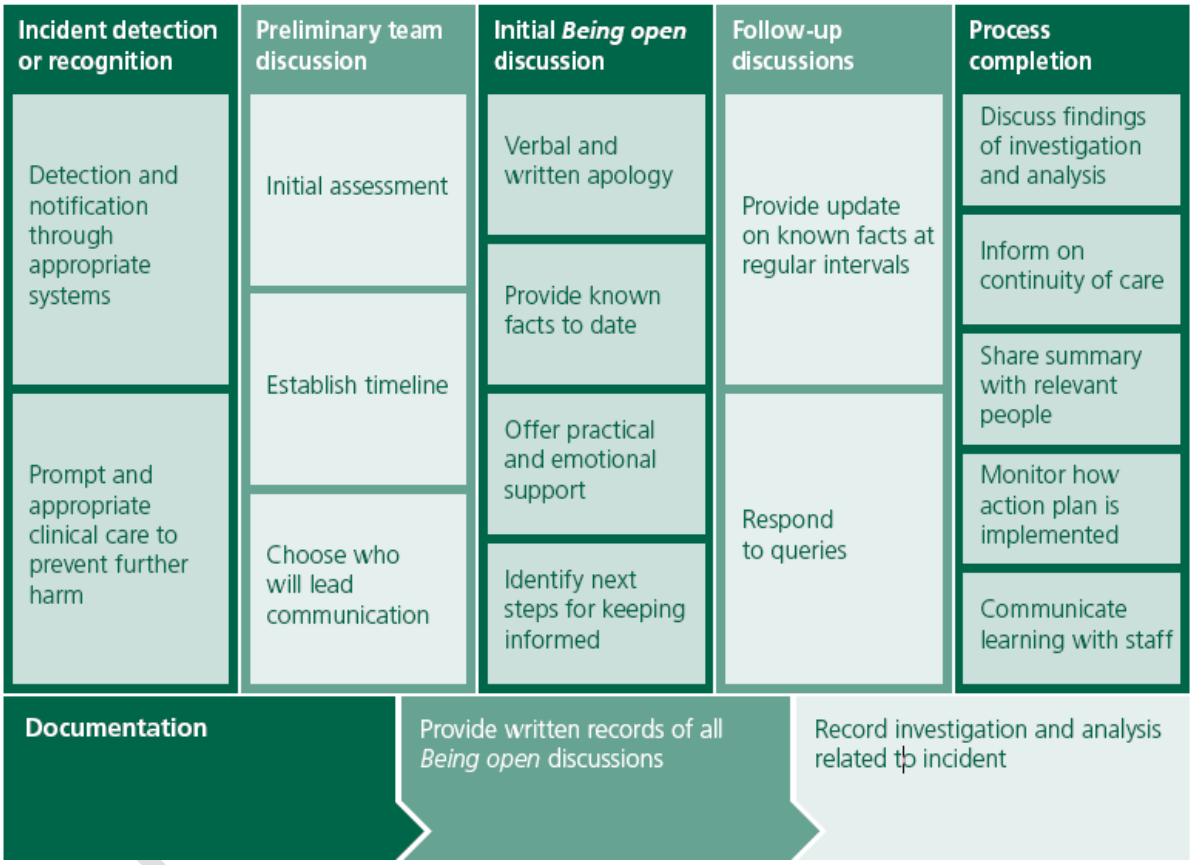
[1] NPSA/2009/PSA003 19th Nov 2009 Being Open

[2] Both the revised (2013) NHS constitution and a guidance handbook are available to down load at http://www.england.nhs.uk/2013/03/26/nhs-constitution/

harm-threshold. The duty is being introduced as part of the fundamental standard requirements for all providers. It will apply to all NHS trusts, foundation trusts and special health authorities from October and the government plans to implement the standards for all other providers by April 2015, subject to parliamentary approval. Its aim is to ensure that openness, transparency and candour are the norm.

The duty of candour is a legal requirement and CQC will be able to take enforcement action when it finds breaches. The Duty of Candour itself will be set out in secondary legislation in regulations.

Overview of the *Being open* process



1. INTRODUCTION

This policy is issued and maintained by the Executive Medical Director and Executive Director of Nursing & Quality (the sponsors) on behalf of the Trust, at the issue defined on the front sheet, which supersedes and replaces all previous versions.

2. POLICY STATEMENT

The purpose of this policy is to provide a best practice framework, based on the guidance of the National Patient Safety Agency (NPSA), to create an environment where patients, their representatives and staff feel supported, and have the confidence to act appropriately and for ensuring that all communications with relevant people are open, honest and occur as soon as possible after an event.

The effects of harming a patient can have devastating emotional and physical consequences for patients, their families and carers. It can also be distressing for the professionals involved. Being open and honest about what happened discussing the incident/complaint/claim fully, openly and compassionately can help all those involved cope better with the consequences of harm, whether potential or actual, in managing the event and also in coping in the longer term. In addition, being open and candid when things go wrong ensures that the investigation gets to the root cause of the event and promotes organisational learning.

'Being Open - a duty to be candid' supports a culture of openness, honesty and transparency and includes apologising and explaining what happened[3] after reflection and with knowledge of all the facts. Openness and honesty at the point of an incident occurring can help prevent such events becoming complaints or litigation claims[4]. *'Being Open'* is endorsed by (among others) the Department of Health, the Medical Defence Union, the NHS Litigation Authority[5], the NHS Confederation and the Royal Colleges. The 'Duty of Candour' has been made a contractual requirement by the DH Operating Framework[6] and has been included as a professional responsibility under the NHS Constitution. This policy will be updated in line with any new provisions once they become available.

[3] NPSA/2009/PSA003 19th Nov 2009 Being Open

[4] NPSA (2009) Saying sorry when things go wrong. Being Open- communicating patient safety incidents with patient their families and staff. NPSA/NRLS pg 2

[5] NHSLA (May 2009) Apologies and Explanations available via NHSLA.com

[6] The NHS operating framework outlines the business and planning priorities for the NHS.

The Trust's Being Open Policy should be read in conjunction with the NPSA (Nov 2009) Policy Document – Being Open - Communicating Patient Safety Incidents with patients, their families and carers; and the Trust's Incident Reporting Policy.

The Trust, through its Being Open Policy:

- Endorses the '10 principles of Being Open' as described within the NPSA Policy;
- Will raise awareness among staff and patients that the Trust has adopted such a policy;
- Will ensure that the Trust's Being Open Policy is fully integrated into the application of related trust policies including:
    - Incident Reporting Policy
    - Serious Incident Process
    - Patient Complaints Handling Policy
    - Claims handling protocol
    - Risk Management Policy
    - Freedom of Information Policy
    - Confidentiality Policy
    - Health Records Management Policy
    - Clinical Record Keeping Standards Policy
    - Raising Concerns – Whistle Blowing Policy & Procedure
    - Supporting Staff Involved in Incidents, Complaints or Claims Policy
    - Disciplinary Rules and Procedures
    - Management of Capability Policy and Procedure
    - Additionally, guidance for staff about statement writing and the support available can be accessed via the Governance Support Unit (GSU)
    - Maternity Risk Management Strategy

Equality Impact Assessment

The Trust is committed to ensuring that none of its policies, procedures and guidelines discriminate against individuals directly or indirectly on the basis of gender, colour, race, nationality, ethnic or national origins, age, sexual orientation, marital status, disability, religion, beliefs, political affiliation, trade union membership, and social and employment status. An Equality Impact Assessment (EIA) of this policy has been conducted by the

author using the EIA tool developed by the Diversity and Inclusivity Committee. (03/09/2014).

3. DEFINITIONS

Being Open – The process by which the patient, their family, their carers are informed about a patient safety incident/complaint/claim involving them.

Candour – an obligation to disclose errors that may not be immediately obvious to the patient. Exercising candour narrows the gap between what the healthcare professional and the patient know about an incident.

Claim – defined by the Clinical Negligence Scheme for Trust (CNST) as: *"any demand, however made, but usually by the patient's legal adviser, for monetary compensation in respect of an adverse clinical incident leading to a personal injury".*

Complaint - any expression of dissatisfaction with care provision, or a perceived grievance or injustice.

Event - any occurrence that results in a patient safety incident, complaint or claim.

Harm: **'No Harm'[7] –** no injuries or obvious harm. No loss of property. No significant likelihood of service issues arising from incident.

Near Miss – / **potential harm -** any unexpected or unintended occurrence or incident that did not lead to harm, loss or damage, but had serious potential to do so and was prevented either by intervention or luck.

'Low harm' – any incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS funded care.

'Moderate harm' – any incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS funded care. A moderate increase in treatment includes an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment or transfer to another area such as intensive care. The definition for moderate harm could cover complications if they are "unintended or unexpected".

'Severe harm' – any incident that appears to have resulted in permanent[8] harm to one or more persons receiving NHS funded care. This includes a

[7] No, low, moderate, severe and death harm and near miss definitions taken from NRLS (2008) A risk matrix for risk managers

[8] Permanent harm is defined as harm that is enduring and cannot be rectified by treatment.

permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb, or organ or brain damage. The definition for severe harm is qualified in that it only applies to the extent that the severe harm related directly to the incident rather than the natural course of the patient's illness or underlying condition.

'Catastrophic or Death' – any incident that directly resulted in the death of one or more persons receiving NHS funded care. The definition for death is qualified in that it only applies to the extent that the severe harm related directly to the incident rather than the natural course of the patient's illness or underlying condition.

Never Event – Are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by the healthcare provider. There are currently 25 Never Events, as determined by the Department of Health[9].

Notifiable Incident - In respect of NHS bodies, a "notifiable safety incident" means any unintended or unexpected incident that occurred in respect of a patient during the provision of regulated activity that, in the reasonable opinion of a healthcare professional, could result in, or appears to have resulted in death, severe harm, moderate harm or prolonged psychological harm.

NRLS – National Reporting and Learning System- the electronic system by which all NHS Trusts inform the NHS Commissioning Board Special Health Authority patient safety incidents. Where a patient safety incident is discovered through a complaint, concern or claim that has not previously been reported, case by case consideration should be given as to whether the incident is reflected on the NRLS retrospectively. It may be considered that the delay in reporting be reported as an incident itself.

Patient Safety Incident - is any unintended or unexpected incident which could have or did lead to harm for one or more patients.

Prolonged Psychological Harm – psychological harm which as service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

RCA – Root Cause Analysis is a systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened. RCA Toolkit. www.npsa.nhs.uk

Staff - means all employees of the Trust including those managed by a third party organisation on behalf of the Trust.

[9] The current list of Never Events can be found on the Department of Health Website and is updated annually

SIRI - Serious Incident Requiring Investigation is any incident occurring in relation to care that is reportable to the Clinical Commissioning Group (CCG). Further explication can be found within the Incident Reporting Policy.

The Trust - means the Sherwood Forest Hospitals NHS Foundation Trust.

This/the Policy - means this Being Open Policy.

4. ROLES AND RESPONSIBILITIES

4.1 Chief Executive Officer – As accountable officer the Chief Executive is responsible for the overall leadership and management of the Trust and its performance in terms of service provision, financial and corporate viability, ensuring the Trust meets all its safety and quality requirements, statutory and service obligations, and for working closely with other partner organisations. The CEO delegates aspects of this responsibility to relevant Executive Directors according to their organisational portfolios.

4.2 Chief Financial Officer - The Director of Finance has delegated authority and responsibility from the CEO for the financial management and probity of the Trust's resources, the management and maintenance of the Trust's estate, audit services, procurement and capital programme management.

4.3 Executive Medical Director - The Medical Director has delegated authority and responsibility within the Trust for clinical practices and outcomes; professional regulation and clinical standards; clinical effectiveness; research and development; information governance (Caldicott Guardian); infection control; safeguarding and relationships with general practitioners.

4.4 Executive Director of Nursing and Quality - The Director of Nursing and Quality has responsibility for overseeing the strategic and operational aspects of safety across the organisation and for nursing and allied professionals and process aspects of patient safety; clinical practices and outcomes; professional regulation and clinical standards; and governance (including compliance, patient safety and experience).

4.5 Director of Operations - The Director of Operations has delegated authority and responsibility from the CEO for cost improvement and transformation and for the overarching day to day management of service provision and implementation of operational policies within the clinical services provided by the Trust, delegating to the Divisional Management Teams, as appropriate.

4.6 Governance Support Unit - has responsibility, led by the Head of Governance, for supporting the Medical Director and Executive Director of Nursing and Quality with the implementation of the strategic and operational aspects of safety.

4.7 Patient Experience Team have a responsibility for signposting patients, relatives and carer; and for the management of the complaints process, ensuring that complainants are listened to and an appropriate explanation sought within the context of '*Being Open*'

4.8 Head of Legal Services – is responsible for the management of the handling of all clinical and non-clinical personal injury claims made against the Trust, in accordance with both statutory and mandatory requirements.

4.9 Divisional / Specialty Care group responsibility and accountability

The multi-professional team, including the senior clinician involved in the care of the patient have responsibility for managing any notifiable safety incident, complaint or claim in line with the relevant policy.

Meeting as soon as possible after the event to:

- Establish the facts of the case
- Assess the incident to determine both the level of harm and the immediate response required
- Identify who will be responsible for the discussion between the patient, and / or their carers, involving the patient experience team if an incident is also the subject of a complaint. Consider whether support from patient advocate, independent healthcare professional or facilitators are warranted.
- Where SIRIs / Never Events are thought to have occurred, to escalate to the Head of Governance and Medical Director who will convene an initial scoping meeting.

In the case of a Serious Incident Requiring Investigation (SIRI), at the initial scoping meeting, a specific member of staff should be identified to liaise with the patient, their relatives or carers and also support them through the investigation process. This should be recorded in the notes of the scoping meeting.

4.10 All Trust staff – All staff, including temporary, agency or volunteer staff, have a responsibility for identifying actual or potential hazards, safety incidents and risks and reporting/escalating issues in accordance with this policy and the Incident Reporting Policy, Risk Management Policy, Patient Complaints Handling Policy and Raising Concerns – Whistleblowing Policy & Procedure.

It is essential that all communication with the patient, their family or carers be fully, explicitly and contemporaneously documented in the medical records. Additionally, where the facilities exist for electronic reporting, the discussion points should be detailed.

5. SCOPE

The Trust is committed to '*Being Open'* and candid; about communicating with patients, their relatives and carers about any failure in care or treatment, whether they be the results via a

- Patient Safety Incident (PSI)
- Concern or complaint
- Claim

This policy deals with the information and methods of sharing that information with patients, relatives and their carers, staff and other healthcare organisations. The extent to which it is enacted will be determined on the grading of the severity of the event. Further information on the grading of harm is contained in the table on page 11&12.

The following Trust policies and procedures should be read in conjunction with this policy:

- Claims Handling Protocol;
- Patient Complaints Handling Policy;
- Incident Reporting Policy;
- Maternity Risk Management Strategy.

6. CONSULTATION

The following groups were consulted before being approved by the Trust Board:

a. Trust Management Board, 28-07-2014 & 27-10-2014

b. Clinical Quality and Governance Board Sub-Committee, 11-06-2014 & 16-10-14

c. Quality Committee members via e-mail 19-09-14

d. Divisional Clinical Governance Meetings for Emergency Care and Medicine, Planned Care and Surgery, Diagnostics and Rehabilitation and Newark in July 2014

e. Individuals were consulted on and included the Interim Complaints Manager, the Learning Disability Nurse Specialist, the Safeguarding Lead/Advisors, the Legal Services Manager, the Interim Information Governance Manager, the Clinical Governance Lead, the Patient Safety Lead, the Clinical Policy and Guidelines Lead, the Datix Administrator, the Interim Risk Manager, the Director of Corporate Services/Company Secretary, the Head of Programme Management.

7. NARRATIVE

7.1 Grading of Response and 10 Principles of 'Being Open'

'*Being Open - a duty to be candid'* begins with the detection of an event. The response should be guided by the level of severity of the event. It is the view of the Trust that it is expected that the patient is informed of any harm arising as a result of a patient safety incident. For this reason, it is a mandatory field in the on-line e-reporting incident form. The NHS Litigation Authority (NHS LA) has issued further guidance which supports and encourages Trusts to apologise to patients. The NHSLA 'Saying sorry' leaflet encourages trusts to apologise to patients. Saying sorry is not an admission of legal liability; it is the right thing to do. The "Saying Sorry" leaflet can be obtained by clicking on the following link: http://www.nhsla.com/Claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf

Table one guides individuals in relation to the level of response required:

Table One

Grade of Incident	Level of response
No harm (including prevented patient safety incident)	Patients are not usually contacted or involved in investigations and these types of incidents are outside the scope of the Being open policy. Individual healthcare organisations decide whether 'no harm' events (including prevented patient safety incidents) are discussed with patients, their families and carers, depending on local circumstances and what is in the best interest of the patient.
Low Harm	Unless there are specific indications or the patient requests it, the communication, investigation and analysis of the event, and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the event. Reporting to the Governance Support Unit will occur through standard incident reporting mechanisms and be analysed centrally to detect high frequency events. Review will occur through aggregated trend data and local investigation. Where the trend data indicates a pattern of related events, further investigation and analysis may be needed. Communication should take the form of an open discussion between the staff providing the patient's care and the patient, their family and carers. **Apply the principles of Being open**
Moderate Harm	A higher level of response is required in these circumstances. The Governance Support Unit should be notified immediately and be available to provide support and advice during the Being open process if required (see * below re Maternity Services). Once the level of harm is validated to be moderate or higher, the 'Being Open' process should be applied. **Apply the Being open process**
Severe, significant Harm or death (SI's, Never Events, IG Grade 3&4 incidents)	A higher level of response is required in these circumstances. The Governance Support Unit should be notified immediately and be available to provide support and advice during the Being open

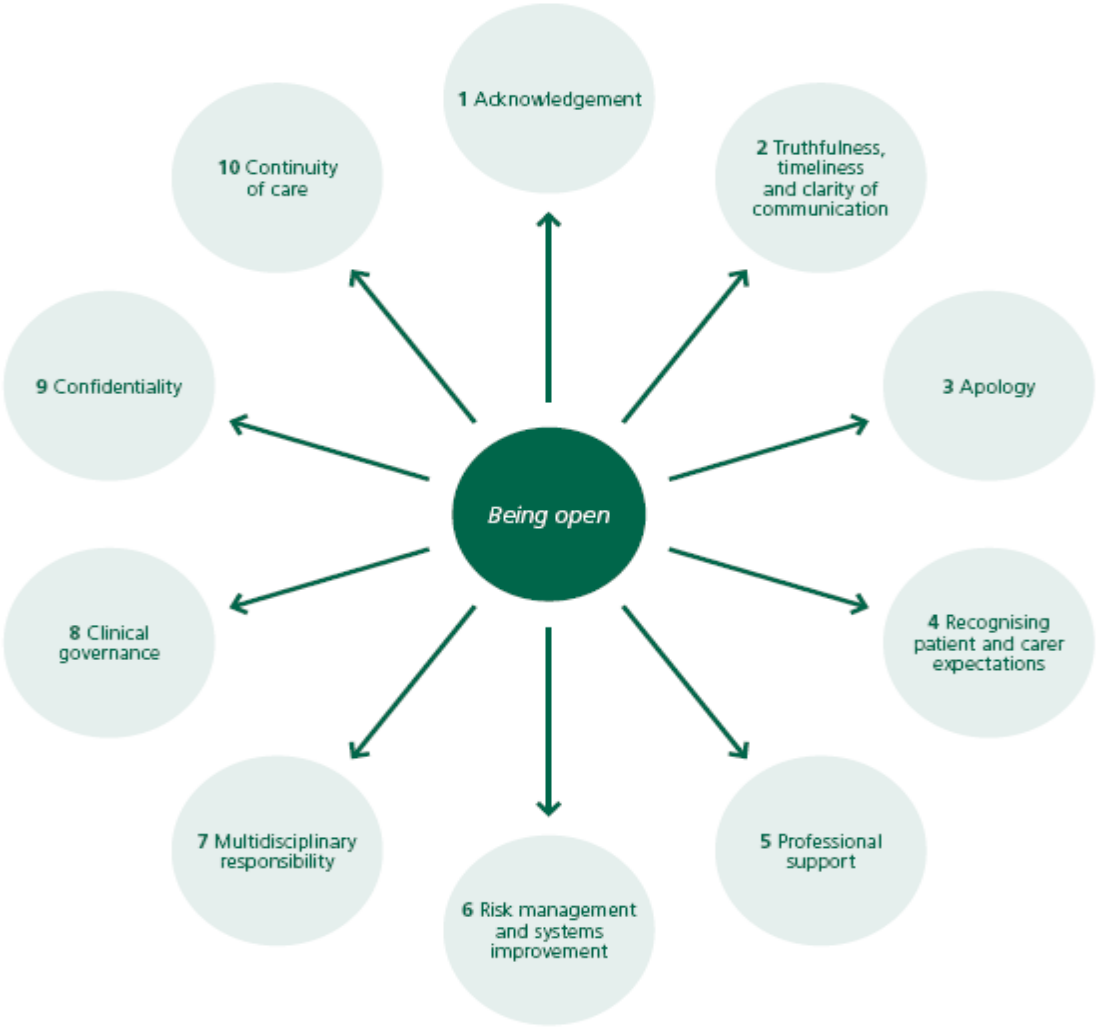
	process if required Where the level of harm is severe or death, additionally, the Executive Director of Nursing and Quality, the Executive Medical Director, the Governance Support Unit and the Divisional management team should also be immediately notified. **Apply the Being open process**

**Maternity Services report a number of 'common' events which occur during pregnancy, labour and the post natal period which have been associated with high litigation costs. These events are described as trigger events and are listed within the Maternity Risk Management Strategy. The aim of trigger event reporting is to ensure these cases are reviewed in order to inform service and practice development and improve care.*

The majority of these events will be graded as 'moderate' as by their nature they lead to further treatment / procedure and an increase in the length of hospital stay.

All trigger events reported will undergo initial review within the service. Unless there are specific indications or the patient requests it, the communication, investigation and analysis of the event, and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the event. Reporting to the Governance Support Unit will occur through standard incident reporting mechanisms and be analysed centrally to detect high frequency events. Review will occur through aggregated trend data and local investigation.

The following principles underpin 'Being Open'. The purpose is to encourage open communication between staff, patients, carers and other healthcare organisations.



For information on the basic principles to be addressed during the being open process, see Appendix A.

7.2 Process for acknowledging, apologising and explaining when things go wrong

The first step of the process is the recognition of an incident and when the level of harm dictates that it is appropriate to apply the 'Being Open - a duty to be candid' policy.

This can be identified by any of the following mechanisms:

- Via staff at the time of the incident
- Via staff retrospectively
- By the patient/ family / carer raising a concern, either at the time, or via a complaint or claim in retrospect
- Via the incident reporting system
- Via other sources, such as the incident being highlighted by another patient, visitor or non-clinical staff
- Via concerns raised following a post mortem result

Where necessary immediate clinical care should be given to prevent further harm.

7.3 Initial Discussion

Following identification of an incident, a preliminary team discussion should be undertaken as soon as possible to the incident, once the patient is safe, to establish:

- Basic clinical facts
- Assessment of the incident and determine level of immediate response required[10]
- Individual responsible for discussing/ liaising with the patient/relative/carer
- Whether patient support is required
- Immediate support required for staff involved
- A clear communication plan

7.4. Identifying who should be responsible

Essential for being open is to identify the person who will be the communicator / support / advocate and represent the Trust/Service for the family to liaise with. Too many different individuals can cause confusion and /or upset with the potential for conflicting information and sometimes fragmentation or even overlooking opportunities. In determining who will be responsible for communicating with the patient/family carers the individual should:

- Have a good relationship with the patient and/or their carers
- Have a good understanding of the relevant facts
- Be senior enough or have sufficient experience and expertise in relation to the type of incident to be credible to patients, carers and colleagues
- Have excellent interpersonal skills, including being able to communicate with patients and/or their carers in a way they can understand
- Be willing and able to offer an apology, reassurance and feedback to patients and/ or their carers
- Be able to maintain a relationship with the patient and/or their carers and to provide continued support and information.
- Be culturally aware and informed about the specific needs of the patient/relatives or their carers
- Advice and support is available from the Patient Safety, Claims and Patient Support services if required.

[10] Where the incident is thought to be potentially SIRI reportable, this process will be conducted during a formal meeting to scope the case e.g. SI review and sign off group. Where the case does not meet this threshold, these discussions should occur within the appropriate clinical team/ care group.

7.5 When should the initial discussion be held?

The initial candid '*Being Open'* discussion with the patient and/or their carers should occur as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred.

Initially, it is worth noting that something has gone wrong but that the cause is not yet known. It must be communicated to the patient and their family/ carers that we will be taking the event extremely seriously, that the event will be investigated and that the findings of the investigations will be shared with them. Through sharing the report, and meeting with the patient and family/carers, the patient will have opportunity to influence the investigation.

7.6 Factors to consider when timing this discussion includes:

- Clinical condition of the patient. Some patients may require more than one meeting to ensure that all the information has been communicated to and understood by them
- Availability of key staff involved in the incident and in the Being Open process
- Availability of the patient's family and/or carers.
- Availability of support staff, for example a translator or independent advocate, if required
- Patient preference (in terms of when and where the meeting takes place and who leads the discussion)
- Privacy and comfort of the patient
- Arranging the meeting in a sensitive location

7.7 Provision of additional support

7.7.1 Support of the patient, their family / carers

Patients, their family/ carers should be provided with support as is necessary during the process of 'Being Open'. At any face to face meeting, they should be encouraged to be accompanied by another family member / friend / representative. Where appropriate, an independent advocate or interpreter should be offered. The patient is also at liberty to request a second or independent review and this should be facilitated.

7.7.2 Information on how patients can access additional support services and other relevant bodies should be offered, for example:

- Governance Support Unit can be contacted on internal extension 6301
- Patient Experience Team can be contacted on internal extension 3588
- Interpretation services via :- 08081890108
- Chaplaincy via internal ext 3047 (Kings Mill) and 5643 (Newark)

7.7.3 External bodies which may be able to provide support for the patient:

- ICAS - Independent Complaints Advocacy Services
- CRUSE (bereavement counselling support)
- IMCA – Independent Mental Capacity Advocate Service

7.7.4 Where the patient is assessed not to have capacity

Where the patient has a formal assessment of lack of capacity, the principles of 'Being Open' still apply. In circumstances where the patient has a registered person with lasting power of attorney (LPA), it may be a legal requirement that they are informed (dependent on the terms of the LPA). If there is no LPA for the patient, it is best practice that the family and or carers for the patient is informed of the incident. The occurrence of this conversation and the grounds for it must be recorded in the patient's medical record.

The Independent Mental Capacity Advocacy Service (IMCA) may also be of benefit. The purpose of the Independent Mental Capacity Advocacy Service is to help particularly vulnerable people who lack the capacity to make important decisions and who have no family or friends that it would be appropriate to consult about those decisions. The role of the Independent Mental Capacity Advocate (IMCA) is to work with and support people who lack capacity, and represent their views to those who are working out their best interests. A copy of “Making Decisions - The Independent Mental Capacity Advocate Service” can be obtained from the following link:
https://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/making-decisions-opg606-1207.pdf

7.7.5 Children and Young People

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.

7.7.6 Maternity

It is important to remember that in maternity services there may be occasions when a high degree of sensitivity is required when considering the Being Open discussion, for example following an unexpected intrauterine fetal death or stillbirth or an unexpected admission to the neonatal unit. In these instances timing of the 'being open' discussion should be determined by the staff caring for her.

7.7.7 Patients with mental health issues

The only circumstances in which it is appropriate to withhold patient safety information from a patient with mental health issues 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.

Only in exceptional circumstances is it appropriate to discuss patient safety incident information with a carer or relative without the express permission of the patient. Staff are advised to discuss such a proposed action with a senior member of the Governance Support Unit.

7.7.8 Patients with learning disabilities

Some Patients with Learning Disabilities may need some additional support to understand the 'being open process'. All attempts should be made to include the person in the process by use of reasonable adjustments such as: additional time to understand the process, alternative communication methods (use as easier read information, pictures/symbols, use of everyday simple language), support in understanding by involving family members or familiar workers, use of an advocate to ensure the patient views are considered and discussed. If the mental capacity of a patient is in question then section 7.7.4 should be followed.

7.7.9 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. Information can be found on the intranet on how to contact the trust's contracted "Interpreting and Translation Services" (link). A code will be required to use the telephone interpreting services (0808 189 0108) – the Out Patient Clinics, Wards and some departments already have codes. For general enquiries please contact the trust's management team/ patient services secretarial team on ext 3831, 3368, 4168.

7.7.10 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 focussing on the needs of the patient, their family and carers and being personally thoughtful and respectful. For Information on how to contact the interpreting and translation service, see section above.

7.7.11 Legal Affairs

Where the duty to be candid raises specific ethical or legal considerations, the Department of legal affairs can be contacted for advice via internal extension 3257.

7.8 Professional support

It can be very traumatic for healthcare staff to be involved in an event. The Trust is committed to ensuring that staff feel supported through the 'Being Open' process. Staff are also encouraged to seek support from their relevant professional body. (See the Trust's 'Supporting Staff Involved in Incidents, Complaints or Claims Policy' for further details).
Additional, confidential support is available to staff from:

- Occupational Health via internal ext. 5135
- Chaplaincy via internal ext. 3047 (Kings Mill) and 5643 (Newark)
- Governance Support Unit ext. 6301
- Staff are encouraged, if appropriate to seek advice from their trade union representative.

Staff will not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or threat to their registration. Where there is evidence to believe that punitive disciplinary action may follow or criminal act has occurred, the NRLS's Incident Decision Tree should be used to ensure a robust and consistent approach. The Incident Decision Tree aims to help the NHS move away from attributing blame and instead find the cause when things go wrong. The goal is to promote fair and consistent staff treatment within and between healthcare organisations. Further information can be found in appendix C.

Incidents relating to employee performance or conduct should be referred to the appropriate divisional human resources (HR) advisor and managed in accordance with the Trust 'Disciplinary Policy' or the 'Performance Management Policy'.

7.9 Risk management and systems improvement

The Trust supports the root cause analysis (RCA) approach to looking at the causes of patient safety incidents. The focus is on improving systems of care. Further details are available in the 'Incident Reporting Policy'.

7.10 Multi professional responsibility

The Trust acknowledges that patient care is delivered through multi professional teams and the investigation into a patient safety incident/ complaint or claim is focused on systems and processes, rather than individuals. For this reason, senior clinicians and managers must participate in the investigation process.

If an expert opinion is sought, individuals must declare any conflict of interest.

7.11 Confidentiality

Details surrounding an event are confidential. Full consideration should be given to maintaining the confidentiality of the patient, carers and staff involved, in line with the 'Data protection confidentiality policy'.

It is good practice to inform the patient, their family and carers about who will be involved in the investigation, and give them opportunity to raise any objections. Communication outside the clinical team should be strictly on a 'need to know' basis. Equally the relatives may need specific questions answered by the investigation process and should be given the opportunity to raise these.

7.12 Continuity of care

Patients have the right to expect that their care will continue, and that they will receive all their usual treatment with the care, respect and dignity that they are entitled to. If the patient has a preference for their care to be delivered by another team, the appropriate arrangements should be made.

7.13 Requirements for documenting all communication

All discussions and communication with the patient, their family or carers should be carefully detailed in the patient medical case notes. Additionally, in reviewing the care for that patient, the interaction with the patient, their family or carers should be detailed within the investigation report.

Where the communication happens as part of the complaints or claims process, this should be documented within the case file.

Where it occurs as the result of a patient safety incident, this will be recorded within the investigation report.

7.14 Process for encouraging open communication between organisations, teams, staff, patients/carers.

'Being Open - a duty to be candid' forms part of education programmes as documented in section 10. These encourage staff to 'be open' with patients, their relatives and carers, and make explicit their requirement to do so.

Where the incident, complaint or claim involves outside agencies (e.g. other healthcare providers, the Commissioners or social services) whether raised by The Trust or the other agency, there is an obligation to fully co-operate with them and to communicate collaboratively with them.

8. EVIDENCE BASE/ REFERENCES

- NHSLA (May 2009) Apologies and Explanations available via NHSLA.com
- NPSA/2009/PSA003 19th Nov 2009 *Being Open*
- NPSA (2009) Saying sorry when things go wrong. Being Open – communicating patient safety incidents with patient their families and staff. NPSA/NRLS

9. MONITORING COMPLIANCE (& Effectiveness)

Compliance with this policy will be monitored through the use of feedback forms and via the review of closed investigation files. Completion of compliance monitoring forms (see Appendix C) is undertaken by the clinical governance co-ordinators (CGC) at the conclusion of the case, in conjunction with the patient safety lead and forms part of the core case file.

Any identified areas of non-adherence or gaps in assurance arising from the monitoring of this policy will result in recommendations and proposals for change to address areas of non-compliance and/or embed learning. Monitoring of these plans will be coordinated by the group/committee identified in the monitoring table overleaf.

Table 2

Element of policy to be monitored	Lead	Tool / Method	Frequency	Who will undertake	Where results will be reported
Process for encouraging open communication	Head of Governance / Patient Safety Lead	Audit of the mandatory field on the e-reporting form	Annual	Datix Administrator	CQ&GC
		Review of every RCA coming via the SI Review and sign off group for closure to gain assurance that the patient has been told and what has been shared with them	Bi-weekly post each SI review and Sign off group meeting	Patient Safety Lead	
Process for acknowledging, apologising and explaining when things go wrong	Head of Governance / Patient Safety Lead	Audit of the mandatory field on the e-reporting form	Annual	Datix Administrator	CQ&GC
		Review of every RCA coming via the SI Review and sign off group for closure	Bi-weekly post each SI review and Sign off group meeting	Patient Safety Lead	
Requirements for truthfulness, timeliness and clarity of communication	Head of Governance / Patient Safety Lead	Audit of the mandatory field on the e-reporting form	Annual	Datix Administrator	CQ&GC
		Review of every RCA coming via the SI Review and sign off group for closure	Bi-weekly post each SI review and Sign off group meeting	Patient Safety Lead	
Provision of additional support as required	Head of Governance / Patient Safety Lead	Audit of the mandatory field on the e-reporting form	Annual	Datix Administrator	CQ&GC
		Review of every RCA coming via the SI Review and sign off group for closure	Bi-weekly post each SI review and Sign off group meeting	Patient Safety Lead	
Requirements for documenting all communication	Head of Governance / Patient Safety Lead	Audit of the mandatory field on the e-reporting form	Annual	Datix Administrator	CQ&GC

		Review of every RCA coming via the SI Review and sign off group for closure	Bi-weekly post each SI review and Sign off group meeting	Patient Safety Lead	
All requirements as above, in the event of a complaint or claim, will be monitored via a questionnaire (appendix D)	Head of Customer Services / Legal Services Manager	Questionnaire at case closure	Annually to Clinical Quality and Governance Group	Patient Experience Manager / Legal Services Manager to compile report	Trust Management Board

10. TRAINING REQUIREMENTS

- '*Being Open - a Duty to be Candid*' forms part of the syllabus for all Trust RCA courses
- '*Being Open - a Duty to be Candid*' is included in Trust induction for all staff
- '*Being Open - a Duty to be Candid*'' is a mandatory component of the junior doctor's education programme
- A training awareness programme to be co-ordinated by the Patient Safety Team within the Governance Support Unit

11. DISTRIBUTION

Following formal approval, this policy will be published to and form part of the trust's suite of 'Governance Policies' accessible to all staff via the intranet within the Corporate Information intranet site.

Once published, information regarding its issue will be emailed by the Governance Support Unit to the following staff for information, dissemination and action as needed:

- Divisional Governance Groups
- Specialty Governance Groups
- (see below for all methods of communication)

12. COMMUNICATION

- A news item will be posted on the INTRANET to raise awareness of the revised policy
- A news item will be included in the monthly 'Staff Briefings'
- An article to be placed in the Trust safety newsletter, 'Safety Matters'

- This document will appear in the 'New and Updated' area of the Intranet
- This document will be both consulted and communicated via the Divisional Governance meetings and cascades to specialty governance meetings
- Via the Medical Managers forum
- Via the Senior Nurse Forum
- Externally to the Links Group
- The investigation report template guidance has been revised and is inclusive of the principles of '*Being Open - a duty to be candid'*

13. AUTHOR AND REVIEW DETAILS

This document will be reviewed after 3 years, or sooner, should new evidence, legislation, guidance or best practice be issued. This edition of the policy occurred before the 3 year date, in line with changes to the NHS Constitution and the implementation of the contractual duty of candour.

Issue/ Version:	4.0
Date Issued:	15 October 2014
Date to be reviewed by:	October 2016
To be reviewed by:	Head of Governance
Executive Sponsor:	Executive Medical Director / Executive Director for Nursing & Quality
Supersedes:	Issue/ version 3, Issued November 2011 – RV November 2014

14. APPENDICES

Appendix A – Basic principles to be addressed during the 'Being Open – a duty to be candid' process

Appendix B – Being Open Audit Tool

Appendix c – Incident Decision Tree

Appendix A - Basic principles to be addressed during the 'Being Open- a duty to be candid' process.

Acknowledgement

All events should be reported as soon as they are identified. Where the concerns are raised by the patient, their family or carers, the concern should be taken seriously from the outset and treated with compassion and understanding by all healthcare professionals.

Notifiable safety incidents: These should be acknowledged and documented in the medical case notes as soon as an incident is identified. The communication with the patient should be initially verbal, with the offer of a written notification. This should be within 10 days of the incident being reported. This will also be documented within the investigation (RCA – root cause analysis) report.

Complaints: These should be acknowledged within 3 working days of receipt

Claims: These should be acknowledged within 14 calendar days of receipt.

Apology

A sincere, meaningful apology for the event should be offered as early as possible where it is clear that there has been an error.

Verbal apologies allow face-to-face contact between the patient and the healthcare team and should be given as soon as staff is aware that an incident has happened. This should be documented in the medical case notes by the clinician holding the '*Being Open*' discussion, and within any response to a complaint. Where the event results in a claim, it will remain the decision of the case manager to assess whether the apology/ or further explanation is subject to privilege and therefore not disclosable. The reason for not apologising or explaining should be documented in the claims case file.

It is important not to delay the apology for any reason, including the setting up of a more formal '*Being Open*' meeting, but the meeting must happen only once there is reasonable assurance that the facts are known and understood. Further guidance from the NHS Litigation Authority, as a leaflet that can be distributed, can be found via the following link:

http://www.nhsla.com/Claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf

Truthfulness, timeliness, clarity of communication and explanation

Patients and their carers can reasonably expect to be informed of if the issues surrounding the event, and its consequences in a face-to-face meeting. They should be treated sympathetically, with respect and consideration. The Information about the event must be relayed in an honest and candid open manner, by the appropriate person, as soon as is practicable. It should be based only on the facts known at the time, and provide the patient with a step-by-step explanation of what happened.

Information should be unambiguous and free from jargon. Care should be taken that patients do not receive conflicting information from different members of the team. Any discussion with the patient, their family or carers should be documented in the medical records at the time of discussion. The patient, family or carer should be informed that there will be an investigation and they should be offered the opportunity to review the final report should they wish. Any medical terminology should be clearly explained. Where appropriate, the patient should be offered the opportunity to contribute to the investigation. For notifiable safety incidents, this will be demonstrated within the investigation report. Complaints will incorporate this into their response to the patient and their family/ carers.

The verbal explanation should be followed by written notification giving specific information.

Appendix B: Being Open Audit Tool

Methodology: to review in total 34 (2 per specialty) investigation reports related to complaint / claim responses on an annual basis by the Customer Services Manager and Legal Services Manager.

Date of event.....

Type of event.....

Case number: Complaint/ claim - delete as appropriate

	Yes	No	N/A[11]	Evidence Source (report / response / case notes as appropriate)
For a patient safety incident, the report evidences that the initial incident was discussed at the time with the patient/ relative/ carer/staff.				
For a complaint, the case file evidences that the event was acknowledged in line with the requirements of the patient/ relative/ carer/staff.				
For a claim, the case file evidences that the event was acknowledged in line with statutory requirements.				
In all cases, there is evidence within the documentation that an apology was offered (N/A response for claims only).				
In all cases, there is evidence within the documentation that an explanation was offered (N/A response for claims only).				
In all cases, there is evidence within the documentation that communication with the patient/relative/carer has occurred.				
In all cases, there is evidence within the documentation that the patient/ carer/ family/staff have been offered available support.				
If the investigation report has not been shared with the patient/family/ carer/staff, or as part of the claims process it was thought not appropriate, this decision making process is documented				

[11] A "Not Applicable" response is only available in non-grey boxes, and then, only for claims cases.

Appendix C – Incident Decision Tree

NOTE NHS England is currently redeveloping the Incident Decision Tree with a plan to relaunch in early 2014.

The Incident Decision Tree aims to help the NHS move away from attributing blame and instead find the cause when things go wrong. The goal is to promote fair and consistent staff treatment within and between healthcare organisations.

Research carried out in the NHS has shown that systems failures are often the root cause of safety incidents. However, the most common response to a serious patient safety incident is to suspend and then discipline the staff involved. This can be unfair to employees and divert management from identifying contributory systems failures. Suspending key employees can also diminish the quality of patient care provided.

The Incident Decision Tree can help managers and senior clinicians:

- decide whether it is necessary to suspend staff from duty following a patient safety incident;
- explore alternatives to suspension, such as temporary relocation or modification of duties; and
- consider other possible measures to be taken as the investigation progresses.

The Incident Decision Tree complements the Root Cause Analysis toolkit.

Link: http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59900