Sussex Community NHS
NHS Trust

Being Open and Duty of Candour Policy & Procedure

Policy Date: April 2015/18

Policy Version (V2.0)

April 2015

TARGET AUDIENCE (including temporary staff)	
People who need to know this document in detail	All clinical staff and all operational managers
People who need to have a broad understanding of this document	All staff who provide a direct service to patients
People who need to know that this document exists	All staff

Policy Author: Complaints and Assurance Lead/ Complaints Manager

Approved by: Patient Experience Group Date: 13.4.15

Ratified by: Trust-wide Clinical Governance Group Date: 26.4.15

Date of next review: April 2018

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1. INTRODUCTION

1.1 Purpose

Sussex Community NHS Trust (SCT) has a genuine commitment to greater openness and candour, to developing a culture dedicated to learning and improvement, which constantly strives to reduce avoidable harm.

SCT is committed to improving patient safety and communication with patients and/or family members/carers when a patient is involved in an incident, which includes moderate harm, (non-permanent harm) severe harm or death. We will also ensure that patients, their carers or family where appropriate, are kept informed of the investigation and any outcomes, with the opportunity to ask questions.

The publication of the Francis Inquiry report in 2013 instigated many changes to health and social care providers, including the drive to improve transparency and openness within the NHS and to provide assurance to our patients that we are doing everything we can to keep them safe.

There is a requirement under the NHS Standard Contract, issued by the NHS England, to ensure that patients and/or their families are told about patient safety incidents that affect them, receive an appropriate apology and are kept informed about investigations.

A statutory duty of candour came in in November 2014 for NHS trusts in addition to registration requirements with the CQC.

Open and effective communication with patients begins at the start of their care and should continue throughout their time within the healthcare system. This should be no different when a patient safety incident occurs, when a patient makes a complaint, or in the case of a lawsuit, claim or litigation.

Being open and our duty of candour relies initially on our staff and the rigorous reporting of patient safety incidents. The Trust endorses the Francis Report recommendation 173 and aims to promote a culture of openness, which it sees as a prerequisite to improving patient safety and the quality of patient's experience.

1.2 Scope

This policy only relates to those incidents, complaints and claims where a patient (or more than one patient) has been harmed, or has the potential to be harmed, as a direct result of when things have gone wrong.

This policy is only applicable for incidents, complaints and claims in which SCT patients and staff are directly involved. The Trust encourages all groups of independent contractors

to adopt this policy, or to develop similar procedures based on the NHS England Patient Safety Division (Formally the National Patient Safety Agency) guidance.

SCT encourages staff to report **all** patient safety incidents, including those where there was no harm, or near misses, via the Trust's electronic reporting system, using the principles set out in the Incident Management and Reporting Policy and Procedure.

Any staffs who are concerned about the non-reporting or concealment of incidents, or about on-going practices which present a serious risk to patient safety, are encouraged to raise their concerns under SCT's Raising Concerns (Whistleblowing) Policy.

1.3 Definitions

Below is a list and the meaning of key terms that appear within this document.

Being Open	Being open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following an incident in which the patient was harmed or had the potential to be harmed. The specific delivery of "Being open" communications will vary according to the severity of harm grading, clinical outcome and family arrangements of each specific event.
Candour	Candour is the quality of being open and honest. Patients, or someone lawfully acting on their behalf, should as a matter of course, be properly informed about all of the elements of their treatment and care.
Care Quality Commission (CQC)	The independent regulator of health and social care in England.
Duty Of Candour	Our statutory duty to follow a specific process in being open when a patient safety incident results in moderate harm, severe harm or death in line with section 2 – Application of Being Open and Duty of Candour.
National Health Service Litigation Authority (NHSLA)	A not-for-profit part of the NHS. The NHSLA manages negligence and other claims against the NHS in England on behalf of its member organisations.
NHS England Patient Safety Division	Lead patient safety organisation for the NHS (formally the National Patient Safety Agency NPSA).
Patient Safety Incident	A "patient safety incident" is defined by the National Patient Safety Agency as, 'any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS-funded healthcare', NPSA 2007.
Root Cause	"A systematic process whereby the factors that contributed to an incident

Analysis	are identified. As an investigation technique for patient safety incidents, it looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which an incident happened". *NPSA National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (2010)*
Serious Incident	Incidents which are deemed 'serious' as defined by the NPSA.
Prolonged Psychological Harm	prolonged psychological harm" means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;

2. APPLICATION OF BEING OPEN & DUTY OF CANDOUR

Incident Level	NPSA Definition of Harm Level	Which Process Applies
No Harm	**Incident prevented** - any patient safety incident that had the potential to cause harm but was prevented, and no harm was caused to patients receiving NHS-funded care. **Incident not prevented** - any patient safety incident that occurred but no harm was caused to patients receiving NHS-funded care.	The NPSA's Being Open policy does not require prevented patient safety incidents or 'No Harm' incidents to be reported to patients/relatives. The decision of whether to communicate these to patients depends on local circumstances and advice should be sought from the senior health care professional concerned.
Low Harm	Any patient safety incident that required extra observation, or minor treatment and caused minimal harm to one or more patients, receiving NHS-funded care. **Minor treatment** is defined as first aid, additional therapy, or additional medication. It does not include any extra stay in hospital or any extra time as an outpatient, or continued treatment over and above the treatment already planned; nor does it include a return to surgery or readmission.	Low harm incidents should be communicated to patients/relatives under the 'Being Open' process.

Moderate Harm	Any patient safety incident that resulted in a moderate increase in treatments and which caused significant but not permanent harm, and or prolonged psychological harm, to one or more patients receiving NHS-funded care. **Moderate increase** in treatment is defined as a return to surgery, and unplanned readmission, 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 as a result of the incident. Prolonged psychological harm which means psychological harm a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.	Being Open principles and application of Duty of Candour Process.
Severe Harm	Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-Funded care. Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiological or intellectual including removal of the wrong limb or organ, or brain damage.	Being open principles and application of Duty of Candour process. Serious Incident requiring investigation process. (Root Cause Analysis)
Death	Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care. The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.	Being open principles and application of Duty of Candour process. Serious Incident Requiring Investigation Process.

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2.1 Understanding the Being Open principles

Being Open recognises that everyone has the right to be treated with respect and to receive fair and dignified treatment. *Being Open* enables the Trust to fulfil its duties to promote human rights in a practical, day-to-day level. It particularly enables the Trust to promote the right to a fair trial and the right to freedom of expression.

Patients are more likely to forgive errors if they are discussed fully and in a timely and thoughtful manner using the Being Open policy. By *Being Open*, staff can lessen the trauma felt by patients following a patient safety incident.

Being Open involves:

- Acknowledging, apologising and explaining when things go wrong;
- Conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons identified will help prevent the incident recurring;
- Providing support for those involved to cope with the physical and psychological consequences of what happened.
- In addition to application of Being Open policy, our statutory duty of candour requires a formal process, which is explained in the next section.

2.1.1 **The benefits for patients**

Our patients receive a sincere apology and explanation when things go wrong and this will support:

- Feeling their concerns and distress have been acknowledged;
- Reassurance the Trust will identify lessons to prevent harm happening to anyone else;
- Reducing the suffering felt when things go wrong;
- Improving respect and trust for the organisation; and
- Reassurance treatment will continue according to clinical needs.

2.1.2 **The benefits for SCT and our staff**

Being Open not only benefits patients, their families and carers, but also healthcare staff and healthcare organisations.

For healthcare organisations and teams, the benefits are:

- An enhanced reputation of respect and trust for the organisation/service/team;
- A reinforced culture of openness;
- Improving the patient experience and satisfaction;
- A reputation for supporting staff when things go wrong;
- Embodying the NHS Constitution for England pledge to patients around Being Open; and
- The opportunity to learn when things go wrong.
- The potential to reduce the costs of litigation;

For our staff, the benefits are:

- Confidence in how to communicate effectively when things go wrong;
- Feeling supported when apologising or explaining to patients, their families and carers;
- Satisfaction that communication with patients and/or their carers following a patient safety incident has been handled in the most appropriate way;
- Improving the understanding of incidents from the perspective of the patient and/or their carers;
- The knowledge that lessons identified from incidents will help prevent them happening again;
- Having a good professional reputation for handling a difficult situation well and earning respect among peers and colleagues; and
- Patients are more likely to forgive errors if they are discussed fully and in a timely and thoughtful manner using the Being Open policy. By *Being Open*, staff can lessen the trauma felt by patients following a patient safety incident.

2.2 SCT policy follows the NPSA 10 principles of Being Open

1. **Acknowledgement**
   All patient safety incidents should be acknowledged and reported on Safeguard as soon as they are identified.

2. **Truthfulness, timeliness and clarity of communication**
   An appropriately nominated person must give information about a patient safety incident to patients, their families and/or their carers in a truthful and open manner.

3. **Apology**
   Patients, their families and/or their carers should receive a sincere expression of sorrow or regret for the harm that has resulted from a patient safety incident, i.e. a meaningful apology. Saying sorry to patients, their families and/or their carers is not an admission of liability.

4. **Recognising patient and carer expectations**
   Patients, their families and/or their carers can reasonably expect to be fully informed of the issues surrounding a patient safety incident and its consequences, in a face-to-face meeting with representatives from the healthcare organisation

5. Risk management and systems improvement

Root Cause Analysis or similar incident investigation techniques will be used to uncover the underlying causes of all relevant patient safety incidents. All investigations should focus on improving systems of care, which will then be reviewed for their effectiveness.

6. Professional support

SCT will create an environment in which all staff, whether directly employed or independent contractors, are encouraged to report patient safety incidents. SCT will ensure staff are supported throughout any incident investigation, as we recognise that they may have been affected. We will not unfairly expose staff to punitive disciplinary action.

7. Multidisciplinary responsibility

The organisation's Being Open policy will apply to all staff who have key roles in a patient's care.

8. Clinical governance

Being Open requires the support of the organisation's patient safety and quality improvement processes through clinical governance frameworks, in which patient safety incidents are investigated and analysed to find out what can be done to prevent their recurrence.

9. Confidentiality

The organisation's Being Open policy should give full consideration of, and respect for, the privacy and confidentiality of patients, their family and/or carers and staff, in line with the CQC's 5 key questions (are services safe, effective, caring, responsive and well led?).

10. Continuity of care

Patients are entitled to expect that they will continue to receive treatment and to be treated with dignity, respect and compassion. If a patient's healthcare needs are to be taken over by another team, appropriate arrangements should be made for transition of care to the new team.

2.3 Applying the statutory duty of candour

Step 1.	**Incident is identified (Moderate or Severe Harm)** An incident may be identified by a patient, a carer, a Trust staff member or an independent contractor. Support must be given to the patient and staff affected. Following an incident, the patient should continue to receive treatment and should continue to be treated with respect and compassion by the Trust staff. Should the patient wish to receive treatment from another healthcare team, arrangements should be made to facilitate this wish, if possible. Patients/relatives/carers should be reassured that the incident and its investigation would not affect the continuing treatment provided.
Step 2.	**Record incident on Safeguard and inform your line manager** An on-line incident reporting form must be completed and the line manager must be notified in accordance with the Trust's Incident Reporting Policy and Procedure. The Duty of Candour box on the Safeguard incident reporting form must be ticked for all Duty of Candour reporting and monitoring purposes.
Step 3.	**Discussion with Senior Staff** A member of staff from the team directly involved in the incident should discuss the incident with their Senior Manager and, the incident should be reported to the relevant Director if appropriate. The team must agree on who will hold the initial disclosure discussion with the patient and / or their family and when this will take place. This will be a member of staff at band 7 or above.
Step 4.	**Initial Disclosure and Verbal apology** A member of the service/ clinical team involved directly with the patient's care should confirm to the patient/relative/carer that an incident has occurred and that this will be investigated. The initial discussion with the patient and/or their carers should occur as soon as possible after recognition of the patient safety incident and must be within 10 working days of the incident occurrence. (see section 2.4 for guidance on holding the discussion). A verbal apology for any distress or harm should be offered at this point as well as written notification confirming the disclosure. (please use the disclosure letter template as a guide, appendix A, send a copy to SCT Patient Safety & Risk Manager and the PALS and Complaints Team)
Step 5.	**Investigation** Senior staff or Quality and Patient Safety Improvement Nurse will carry out an RCA investigation. In the event of a serious incident (as defined by NHS England guidelines), the Serious Incident Review Group (SIRG) will review the investigation findings. In all cases the outcome of the

	investigation and draft of the 'Investigation Findings and Apology letter' (appendix B) will be reviewed by Deputy Chief Operating Officer. If a complaint has also been received in relation to the incident, the 'Investigation Findings and Apology letter' will be reviewed and signed by the Chief Executive.
Step 6.	**Outcome and Written Apology** After completion of the incident RCA investigation, feedback should take the form most acceptable to the patient. The manager or clinician must contact the patient (or next of kin) within 10 working days on completion of the investigation review to offer to discuss the outcome of the investigation, including any learning. The investigation summary and 'Investigation Findings and Apology letter' should then be offered to the patient/relative/carer and a copy sent to SCT Patient Safety & Risk Manager and the PALS and Complaints Team.
Step 7.	**Feedback** The patient/relative/carer should be given the opportunity to respond to the findings with any feedback documented and responded to as required. A copy should be sent to SCT Patient Safety & Risk Manager.
Step 8.	**Action Plans** Copies of action plans should be sent to the SCT Patient Safety & Risk Manager and the PALS and Complaints Team.
Step 9.	**Communication of Learning** Effective communication with staff is a vital step in ensuring that recommended actions are fully implemented and monitored and to increase awareness of patient safety and the value of Being Open. Team meetings, newsletters and the Trust website are all available to help communicate with staff.

2.4 Factors to consider - Holding a Candid Being Open Discussion and meetings

2.4.1 Disclosure Discussion

The purpose of a disclosure discussion is to inform a patient/family/carer that an incident has occurred and to offer an apology and sympathetic support. Verbal communication should always occur before a letter is sent. It is useful to identify an appropriate senior staff member to be a single SCT point of contact.

It is important to avoid giving too much detail about the incident until the incident investigation has been completed.

The patient/family should be offered an opportunity to meet to discuss the details of the incident.

This is usually at the end of the investigation so that findings can be shared and discussed, but may also occur before the investigation starts, or during the process. The approach is agreed with the patient/family. The patient/family may request meetings at any stage during the investigation. Patient/family concerns and preferences should be recorded and considered in the investigation.

A summary of the discussion and support needed will be made and followed up in writing using the template provided in Appendix A.

2.4.2 Practical factors to consider before arranging a being open /duty of candour meeting.

These include:

- The 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
- The availability of key staff involved in the incident
- The requirement for truthfulness, timeliness and clarity of communication
- The availability of the patient's family and/or carers
- The availability of additional support, for example an interpreter or an independent advocate, if required
- Patient preference (in terms of when and where the meeting takes place and who leads the discussion)
- The patient/relative/carer may express a preference regarding which staff should attend the meeting, this must be respected
- Privacy and comfort of the patient
- Arranging the meeting in a sensitive location.
- Saying sorry to a patient/relative/carer is not an admission of liability;

2.4.3 Identify support needed by Patient/Relative/Carer/Staff

Patients/relatives/carers may need support from the PALS and Complaints team, an independent patient advocate or interpreter at any stage throughout the process and how to access these should be reiterated at regular intervals throughout the procedure. Staff should facilitate this process. If a patient is incapacitated because of the incident and does not have relatives/carers to assist them, an independent representative may be assigned.

Staff members involved in the incident may also be affected and should be fully supported by their line manager. The HR team, Occupational Health and Staff Counselling are additional sources of support, if required. See Appendix C for a list of contacts.

2.4.4 Face to Face Meeting with Patient/Relative/Carer and appropriate members of the Trust staff.

A meeting should be offered and set up at the earliest convenience to discuss the incident and the issues involved. The patient/relative/carer may express a preference for which staff should attend the meeting.

Trust staff should introduce themselves and explain their role.
An official, independent interpreter should attend if required. If the patient/relative/carer requires any support to deal with the consequences of the incident, information on where this support can be obtained should be provided.

Information may also be provided on the Trust's PALS and Complaints Procedure.

Patients/relatives/carers should be advised who their information will be shared with and may raise objections to this. When information has to be shared to meet legal requirements, or disclosure is justified in the public interest, information may be shared without the patient's consent. Staff should raise any concerns with their line manager and escalate to the Information Governance Lead when necessary.

Trust staff should consider that the patient/relative/carer might express anger or anxiety during the meeting and respond appropriately and professionally. In the event that the patient/relative / carer decline a meeting, this should be recorded.

2.5 Incident Investigation

An investigation into the cause of the incident must be conducted in accordance with the Trust's policies and procedure for Serious Incidents (SI's) or Complaints. This reflects that incidents usually result from system failures, rather than individual actions, and ensures that all possible contributory factors are identified and taken into account. The investigation should include the use of the Root Cause Analysis approach.

The manager or clinician must contact the patient (or next of kin) within 10 working days on completion of the investigation to offer to go through the outcome of the investigation, including any lessons identified. A copy of the investigation summary should be provided to the patient or next of kin (please use Outcome letter template as a guide – Appendix B).

Patients/relatives/carers should be given regular updates on the progress of the investigation either verbally/written/or by further meetings, adhering to the principles in previous stages of this procedure. Before information is provided to the patient/relatives/carers, this should be confirmed by an appropriate senior member of staff involved in the investigation.

The Serious Incident Review Group (SIRG) for Serious Harm incidents or Deputy Chief Operating Officer for Moderate Harm Incidents must approve investigation Reports, before they can be shared with patients/relatives/carers.

The following guidelines should assist in making the communication effective

- The discussion should occur at the earliest practical opportunity, once there is additional information to report
- Consideration should be given to the timing of the meeting/discussion, based on both the patient's health and personal circumstances
- 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 patient and/or their carers should be offered an opportunity to discuss the situation with another relevant professional where appropriate
- A written record of the discussion should be kept and shared with the patient and/or their carers
- All queries should be responded to appropriately
- If completing the process at this point, the patient and/or their carers should be asked if they are satisfied with the investigation and a note of this made in the patient's records (see section 2.7)
- The patient 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.

2.6 Documentation

The communication of patient safety incidents must be recorded. Duty of Candour disclosures and meetings must be recorded on Safeguard records with the time, place, and date as well as the name and relationships of all attendees and the outcome. Required documentation includes:

- incident reports
- records of the investigation and analysis process
- Copies of all correspondence to the patient or next of kin.

There should also be documentation of discussion meetings regarding the incident, including:

- the time, place, and date, as well as the name and relationships of all attendees
- the plan for providing further information to the patient and/or their carers
- offers of assistance to the patients/family or carer

- questions raised by the family and/or carers or their representatives and the answers given
- plans for follow-up;
- progress notes relating to the clinical situation and an accurate summary of all the points explained to the patient and/or their carers
- copies of letters sent to patients, carers and the GP for patient safety incidents not occurring within primary care
- copies of any statements taken in relation to the patient safety incident
- A copy of the incident report.

2.7 Outcome, Feedback and Written Apology post investigation

2.7.1 Feedback on the outcome of the investigation

After completion of the incident investigation, feedback should take the form most acceptable to the patient, but in all cases put in writing (see Appendix B for letter template). The manager or clinician must contact the patient/family or carer within 10 working days on completion of the investigation to offer to go through the outcome of the investigation, including any lessons identified. A copy of the investigation summary will be offered to the patient or next of kin.

The feedback must include:

- The chronology of clinical and other relevant facts
- Details of the patient's and/or their carer's concerns and complaints
- A repeated meaningful apology for the harm suffered and any shortcomings in the delivery of care that led to the patient 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 patient; where investigations are pending coronial processes; where specific legal requirements preclude disclosure for specific purposes. In these cases the patient will be informed of the reasons for the restrictions
- The patient/relative/carer should be given the opportunity to respond to the outcome of the investigation, with any responses documented.

2.7.2 Patients / Relatives/ Carers not satisfied with the outcome

Should this occur, a mutually acceptable mediator should be arranged, to help identify areas of disagreement. Each point of disagreement should be addressed and a response

provided in writing. The patient/relative/carer should also be informed how to make a formal complaint, in accordance with the Trust's Complaints Procedure.

2.8 Special Circumstances/Exceptions

The approach to Duty of Candour may need to be modified according to the patient's personal circumstances and the below should be taken into consideration.

2.8.1 When the incident occurs in another organisation

In the event a patient safety incident has occurred in another organisation e.g. when a patient is transferred into the Trust from another healthcare provider, the individual who first identifies an earlier patient safety incident must notify the Patient Safety & Risk Manager who will make arrangements to establish whether:

- the patient safety incident has already been recognised;
- the process of Being Open has commenced; and
- An incident investigation is underway.

2.8.2 Delayed discovery of an incident

On occasions, incidents become known as the result of a specific review or audit. Where this happens, it is important to look at the resulting investigation and the time that has elapsed since the initial incident. It is important to consider the impact the information may have on the patient's family and/or carer and consider whether the policy still applies. The Medical Director must make this decision.

2.9 Identifying Lessons and Communicating these

2.9.1 Identifying lessons

It is essential that any duty of candour investigation identifies lessons to minimise the possibility of recurrence of the events that led to harm.

Action plans should be devised to manage these and the progress of these should be reported through the clinical governance structures.

Lessons identified will be communicated during the discussion with patients/families/carers affected by the incident.

2.9.2 Communication of changes to staff

Effective communication with staff is a vital step in ensuring that recommended changes are fully implemented and monitored, and to increase awareness of patient safety and the value of Being Open. Team meetings, patient stories to the board, newsletters and the Trust website are all available to help communicate with staff

3. RESPONSIBILITIES

Chief Executive
The Chief Executive is ultimately responsible for ensuring the safety of patients, visitors and staff within the organisation. It is therefore the Chief Executive's responsibility to ensure that there are robust systems in place by which the principles of "*Being Open*" are implemented within the organisation. The Chief Executive is responsible for ensuring that this policy is implemented within all areas of the organisation through responsible Executive Directors, Clinical Directors, Heads of Services and Team Leaders.

All Managers
All Managers are responsible for ensuring all staff are encouraged to report incidents; that all patients, their families, visitors, carers and others are communicated with in a timely manner, with openness and honesty; and that all communication is documented.

All Staff
All staff involved in an incident resulting in long term injury or death need to understand the Being Open policy and follow the accompanying Being Open Process (available on the intranet). A senior manager or senior responsible person will support any junior staff involved in the Being Open process.

All staff are required to complete in full and as directed any templates or proformas as instructed, for use as part of this policy.

4. ASSOCIATED DOCUMENTS AND REFERENCES

Elements of the *Being Open* policy are related to other government directives, initiatives and recommendations, including:

- National Health Service (NHS) Constitution for England, which includes a pledge to patients in relation to complaints and redress;
- Listening, Responding, Improving - A guide to better customer care. Six principles of good complaint handling;
- Health and Social Care Act 2009 that states, 'service providers encourage and support a culture of openness';
- National Health Service Litigation Authority (NHSLA) 'Apologies and Explanations' which encourages healthcare professionals to apologise and provide explanations to patients harmed as a result of healthcare treatment';
- Recommendations in the 5th Shipman Inquiry Report about appropriate documentation of patient deaths;
- NHS Litigation Authority's *Striking the Balance* initiative on providing support for healthcare professionals involved in a complaint, incident or claim;

- Recommendations in the Francis report into the failures of care at Mid Staffordshire NHS Foundation Trust;
- Clywd and Hart *Review of the NHS Hospitals Complaints Process – Putting Patients Back in the Picture*;
- Transforming Care: A national response to Winterbourne View Hospital, Department of Health (2012);
- A Promise to Learn - a commitment to act: Improving the safety of patients in England, (2013);
- Hard Truths: The Journey to Putting Patients First (2014);
- National Patient Safety Agency's (NPSA) framework, 'Being Open: communicating patient safety incidents with patients, their families and carers'; and
- Compliance with the NPSA's 'Seven Steps to Patient Safety for Primary Care', in particular Step 5: 'Involve and Communicate with Patients and the Public'.

Further references:

- Apologies and Explanations NHSLA, May 2009 http://www.nhsla.com/NR/rdonlyres/00F14BA6-0621-4A23-B885-FA18326FF745/0/ApologiesandExplanationsMay1st2009.pdf
- Patient Safety Alert NPSA/2009/PSA003 NPSA, London, November 2009
- Patient Safety Alert NPSA/2009/PSA003 Being Open – Supporting Information NPSA, London, November 2009
- Safer Practice Notice 10, 'Being Open When Patients Are Harmed' NPSA/2005/10 NPSA; London; 2005

What is a patient safety incident? http://www.npsa.nhs.uk/nrls/reporting/what-is-a-patient-safety-incident/

- Confidentiality Code of Practice, Department of Health, 2013.
- CQC regulation 20 http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf

5. MONITORING COMPLIANCE

Compliance against this policy will be overseen by the Trust-wide Clinical Governance Group. Additionally, all Root Cause Analysis investigations into Serious Incidents are checked to ensure they have followed *Being Open* via the Trust's Serious Incident Review Group, with further scrutiny via the Clinical Commissioning Group's Scrutiny Panel.

6. DISSEMINATION AND IMPLEMENTATION

This policy is available on the intranet, and publicised through Contact (the Trust internal electronic newsletter).

This policy will be made available on the intranet, and publicised through Contact (the Trust internal electronic newsletter).

7. CONSULTATION, APPROVAL, RATIFICATION & REVIEW

This policy has been reviewed by:

- Members of the Patient Experience Group;
- The Head of Clinical Governance;
- The Patient Safety and Risk Manager; and
- The Information Governance Lead.

The policy will be approved by the Patient Experience Group and ratified by the Trust-Wide Clinical Governance Group.

8. VERSION CONTROL

Record of Changes		
Date	Version	Changes / Comments
31.03.15	1.0	Updated to reflect new statutory guidance on Duty of Candour

Appendix A – Initial Disclosure Letter Template

Private & Confidential (SERVICE ADDRESS)
(Name and address)

Phone:ADD

Incident No: ADD

Date ADD

sc-tr.serviceexperience@nhs.net
www.sussexcommunity.nhs.uk

Dear NAME OF PATIENT OR RELATIVE

Further to our discussion on …….(ADD). I am writing to confirm that You/Your ……(insert name of relative) have/has been involved in an incident, which related to ……(brief description of the incident) on (date).

On behalf of the Trust and members of the team involved in the care of your son/daughter/father/mother (insert name) please accept our sincere condolences at this sad time.
Or
Please accept my sincere apology that this has occurred.

As a Trust we aim to provide a quality service to patient/service users and families and will investigate incidents promptly. We will also ensure that our findings are shared with those involved and will endeavour to keep you informed of our investigation progress and the outcome of our findings.

We will do everything we can to support you and your family during this process, in line with our Being Open and Duty of Candour policy.

IF INVOLVES A LOSS OF RELATIVE ADD - Please be assured that it is not our intention to intrude upon you or your family at this difficult time, however, we would like to keep you informed.

If you have any queries about this letter please do not hesitate to contact me. (or named Quality and Patient Service Improvement Nurse)
(provide details of any support organisations etc)

Yours sincerely

Name
Role
Sussex Community NHS Trust

Appendix B – Investigation Findings and Apology Letter

Private & Confidential (SERVICE ADDRESS)
(Name and address)

Phone: ADD

Incident No: ADD

Date ADD

sc-tr.serviceexperience@nhs.net
www.sussexcommunity.nhs.uk

Dear NAME OF PATIENTRELATIVE

Please find below a summary of our investigation into the incident which happened on (date).

Description:

Immediate Action Taken:

Investigation Findings:

Lessons Learned:

How these lessons will be shared across the organisation:

I hope you can be assured that we have taken this matter seriously and acted to ensure that this does not occur in future. Once again I would like to offer my sincere apologies for …… on behalf of Sussex Community NHS Trust.

If you have any queries about this letter please do not hesitate to contact me.

Yours sincerely

Name
Role
Sussex Community NHS Trust

Appendix C – Support for Patients / Families / Carers and Staff

SCT PALS – Patient Advice and Liaison Service – 01273 242292

Find out more about local services at Patient UK - www.patient.co.uk

National organisations

The Child Bereavement Trust
Aston House, West Wycombe, High Wycombe, Bucks HP14 3AG
Information and support service line: 0845 357 1000
enquiries@childbereavement.org.uk
www.childbereavement.org.uk
National UK charity providing specialised training and support for professionals to help them respond to the needs of bereaved families.
Resources and information for bereaved children and families as well as the doctors, nurses, midwives, teachers, police, emergency services and voluntary sector support services.

Cruse Bereavement Care
Cruse Bereavement Care, Cruse House, 126 Sheen Road, Richmond TW9 1UR
Tel: 0870 167 1677
www.crusebereavementcare.org.uk
A charity providing information to anyone who has been affected by a death.
Also offers education, support, information and publications to anyone supporting bereaved people. A national charity with over 6,000 trained counsellors.

Supportline
PO Box 1596, Ilford, Essex, IG1 3FW
Helpline: 020 8554 9004 (opening hours vary)
www.supportline.org.uk
A helpline providing confidential emotional support to children, young people and adults on any issue - referring callers to sources of help in their immediate area.

British Association for Counselling and Psychotherapy
1 Regent Place, Rugby, Warwickshire CV21 2PJ
Tel: 0870 443 5252
www.bacp.co.uk
The 'Seeking a Therapist' section of the website gives lists of qualified counsellors and psychotherapists available in your area. This service is also available over the phone.

Jewish Bereavement Counselling Service
PO Box 6748, London N3 3BX
Tel: 020 8349 0839/020 8343 8989
www.jvisit.org.uk/jbcs/
The service is offered to any member of the Jewish community at no charge.

Depression Alliance
35 Westminster Bridge Road, London SE1 7JB
Textphone/Minicom: 020 7928 9992

www.depressionalliance.org
A UK charity offering information to people with depression; run by sufferers.

Samaritans
Helpline: **Samaritans**
Helpline: 08457 90 90 90 (24 hours)
www.samaritans.org
24-hour confidential emotional support for anyone in a crisis.

If I Should Die
www.ifishoulddie.co.uk
This website looks at all aspects of bereavement from the practical to the emotional.

Support for carers
The Princess Royal Trust for Carers
142 Minories, London, EC3N 1LB
Tel: 020 7480 7788
www.carers.org
Information, support and practical help for all carers through a network of Princess Royal Trust for Carers centres.

Carers UK/ Carers National Association
20-25 Glasshouse Yard, London EC1A 4JS
Helpline: 0808 808 7777 (freephone, 10am-12noon and 2pm-4pm, Mon-Fri)
www.carersuk.org.uk/about/main.htm
Runs a helpline and provides support, encouraging carers to recognise their own needs. There is also an information officer to answer enquiries from professionals.

Age UK
www.ageuk.org.uk
England, Scotland, Wales: 0808 800 6565 (freephone)
Northern Ireland: 0808 808 7575 (freephone)
The lines are open Mon-Fri between 9am-4pm.
Free national information service for senior citizens, their carers and relatives.

Alzheimer's Society
www.alzheimers.org.uk
Devon House
58 St. Katharine's Way
London, E1W 1LB
0207 423 3500
Helpline: 0300 222 1122

Help for young people
www.rd4u.org.uk
rd4u
Cruse Bereavement Care, Cruse House, 126 Sheen Road, Richmond, Surrey
TW9 1UR
Helpline: 0808 808 1677 (answered by trained volunteers aged between 16-
25,
4pm-7pm, Mon-Wed)
The youth branch of Cruse, set up to help young people after the death of someone close.

Winston's Wish
The Clara Burgess Centre, Gloucestershire Royal Hospital, Great Western
Road, Gloucester GL1 3NN
Helpline: 0845 2030405 (9.30am-5pm, Mon-Fri; 9.30am-1pm, Sat)
www.winstonswish.org.uk
Charity that offers support to young people who have experienced bereavement.

ChildLine
Helpline: 0800 1111
www.ChildLine.org.uk
Free, 24-hour helpline for children and young people who need to talk about any problem they may have.

Childhood Bereavement Network
www.childhoodbereavementnetwork.org.uk
Huntingdon House, 278-290 Huntingdon Street, Nottingham NG1 3LY
Tel: 0115 911 8070
A new national resource for bereaved children and young people, their parents and caregivers.

Appendix D

Illustrative Examples of Incident that triggers the threshold for the Duty of Candour Regulation.

These examples have been developed by the CQC with stakeholders to illustrate examples of notifiable safety incidents that trigger the threshold for the duty of candour regulation. The examples presented are illustrative only and not an exhaustive list.

Where possible the examples used are sourced or adapted from the following two documents: 'Seven steps to patient safety for primary care' (National Patient Safety Agency 2006) and 'Duty of Candour Threshold Review Group Review of Definitions' (Royal College of Surgeons 2014).

Example	Interpretation
A patient incurs an extravasation injury (soft tissue burn) from an intravenous line causing irreversible scarring and bone damage.	This would be an example where an incident appeared to have resulted in severe harm
A confused elderly patient was supposed to have 1:1 supervision on a medical ward. The patient was left unsupervised for a period of time whilst the shift change was occurring, and the patient fell out of bed, sustaining a severe head injury from which they later died.	This would be an example where an incident resulted in death
A 71 year old woman with apathy and memory loss is diagnosed with dementia. She is treated for several months in the memory service before she is re-evaluated and diagnosed with depression, which responds to antidepressant treatment.	This would be an example of an incident leading to prolonged psychological harm

The Trust aims to design and implement services, policies & other procedural documents and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

Under the Equality Act 2010, policy or other procedural document authors have a statutory duty to give "due regard" to issues of race, disability, gender (including transgender), religion or belief, age, sexual orientation and human rights when developing their policy or other procedural document. This means that policy or other procedural document authors have to assess the potential for their document to discriminate on any of these grounds. Alternatively, the impact of the policy or other procedural document on these groups might be positive or the same for everyone.

1 Name of Policy or Service	Being Open and Duty of Candour Policy

2 Service and Directorate	Clinical Governance Team, Clinical Quality Division

3 Objectives **What is the purpose of this policy or service?**	The Being Open and Duty of Candour policy outlines the principles and procedures that support the Trust's commitment to greater openness and candour in line with the Statutory Duty of Candour, November 2014 and Regulation 20: Duty of Candour, CQC.

4 Analysis completed By (Author? Equality Lead? Other?)	**a) Name**	**b) Job Title**
Author	Mary O'Keeffe	Complaints and Assurance Lead
Author	Nicky Welfare	Complaints Manager

5 Does the policy or service have an effect on Staff and/or the Public? (please √)				
Staff	Yes		No	√
Public	Yes		No	√

Equality law protects people on the following grounds:	Is your policy or service relevant to this area of equality or human rights?		If relevant, is the effect positive or negative		Evidence of the effect (e.g. statistics, research, surveys, results of engagement, etc)	Is further action required?	
	Yes	No	Positive effect	Negative effect		*Yes	No
Age		√					
Disability		√					
Gender (including pregnancy and maternity)		√					
Transgender		√					
Race and Ethnicity		√					
Religion and Belief		√					
Sexual Orientation (including civil partnership)		√					
Human Rights		√					

* Complete the following Equality Analysis Action Plan only for equality grounds marked: *Yes further action required.

Equality Analysis Action Plan								
Equality grounds ticked *Yes requiring further action:	**Does your policy or service:**			**Any action taken to date**	**Action to be taken**	**Target date**	**Responsible Person(s)**	**Expected Outcome (including monitoring arrangements)**
	Discriminate?	**Eliminate discrimination or promote equality?**	**Promote good relations between groups?**					

Equality Analysis: Equality and Diversity Lead sign off			
Signed		**Date**	

Sussex Community NHS
NHS Trust

RATIFICATION CHECKLIST
INSERT NAME OF GROUP MEETING INSERT DATE OF MEETING

Agenda Item: The meeting administrator should be able to provide this
Policy Title **Being Open and Duty of Candour Policy**
Policy Author Complaints and Assurance Lead/ Complaints Manager
Presented By Complaints and Assurance Lead/ Complaints Manager
Purpose **Ratification**

Checklist for Ratification			
1	**Format**		
	Has the standard SCT template been used?	**Yes**	Comments:
2	**Consultation**		
	Please identify who has been consulted in the writing of this document: Patient Safety and Risk Manager, Medical Director and Patient Experience Group		
	Does the committee agree that the right people been consulted with?	**Yes**	Comments
	Does anybody else need to be consulted prior to ratification:	**No**	Please state who:
3	**Approval**		
	Please state the name of the Group that has approved this document?	Name: patient Experience Group	
	Date of Group Approval	Date:	
4	**Equality Analysis**		
	Has the Equality Impact Assessment been completed?	**Yes**	Comments
5	**Review**		
	Please state the timescale for review:	Bi-Annual	

For completion by the Chair of the Committee	
Policy Ratified	**Yes**
Signature of Chair Richard Quirk (Executive Director) (Print Name): Richard Quirk	

Additional actions required for ratification:	