Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Being Open and discharging our Duty of Candour Policy

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P033	Associate Director for Statutory Delivery	Quality and Standards Committee	3 Years

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1. Introduction

The Trust recognises that promoting a culture of openness is a prerequisite to improving service user safety and the quality of healthcare systems. It involves apologising and explaining what happened to service users who have been harmed as a result of their healthcare treatment or when things have gone wrong.

It is important to stress that adopting the formal "Being Open" term does not suggest that the Trust is not generally open. It is common practice within the Trust to share information in an open way and involve service users and carers in care and treatment.

The Trust recognises its contractual and statutory duties to ensure service users and families are informed of notifiable patient safety incidents causing moderate or severe harm, or death.

2. Policy Statement

The Trust will create a culture of openness, particularly when things go wrong and engender a reputation of respect and trust for the organisation. It will uphold the NHS Constitution pledge to patients around Being Open and actively support its staff when things go wrong. Through this approach, the Trust hopes to improve the patient experience and satisfaction with the organisation and provide great opportunities to learn when things go wrong.

The Trust has adopted the following best practice principles towards being open:

- Principle of acknowledgement
- Principle of truthfulness, timeliness and clarity of communication
- Principle of apology
- Principle of recognising service user and carer expectations
- Principle of professional support
- Principle of risk management and systems improvement
- Principle of multidisciplinary responsibility
- Principle of clinical governance
- Principle of confidentiality
- Principle of continuity of care

These principles are explained in detail in the Being Open Procedure

The Trust will monitor to ensure it fulfils its contractual and statutory duties in relation to discharging its Duty of Candour in the spirit of openness, candour and transparency as follows:

- Openness: Enabling concerns to be raised and disclosed freely without fear and enabling questions to be answered.
- Candour: Ensuring that service users harmed by a notifiable patient safety incident are informed of the fact and that an appropriate remedy is offered.
- Transparency: Allowing true information about outcomes to be shared.

3. Purpose or Aim

This policy aims to provide a best practice framework for Being Open for the organisation.

Being Open involves

- Acknowledging, apologising and explaining when things go wrong;

- Conducting a thorough investigation into the incident and reassuring service users and / or their carers and family that lessons learned will help prevent the incident recurring;
- Providing support to cope with the physical and psychological consequences of what happened.

It also provides guidance to support information sharing for those that are not service users, families or carers, that are affected by the actions of service users.

This policy aims to provide and signpost the framework by which the Trust will ensure its statutory and contractual Duty of Candour obligations are fulfilled.

4. Scope

This policy applies to all activities within the Trust and to all staff

5. Content

The Being Open Procedure describes in detail how Being Open is enacted within the Trust.

Specifically it addresses:-

- The need for effective and ongoing communication between all stakeholders.
- The signposting and accessing of advocacy and support for patients and others affected. In the case of homicides committed by service users of the Trust, the Trust will offer externally sourced advocacy support to the immediate family of the victim affected by the tragedy in relation to the consequences of the homicide. The offer of this provision will be over and above any ongoing care and support the Trust may be providing itself.
- Guidance on how to respond to individual patient's personal circumstances and needs.
- How staff are supported.
- How Being Open discussions should be recorded.
- How to ensure the continuity of care.

The Trust will promote its Being Open arrangements through the availability of a Being Open Leaflet available for service users, carers and the public, and which will be displayed in all relevant public areas.

The Duty of Candour procedure describes in detail how the Trust will discharge these obligations. Specifically it addresses:

- The definition of notifiable patient safety incident.
- The threshold by which Duty of Candour obligations are triggered.
- Timescales and recording obligations.
- Sanctions.
- Guidance for staff
- Monitoring arrangements.

6. Legal Considerations

Staff are often unclear about who should talk to service users when things go wrong and what they should say, fearing that they may be admitting liability. The NHS Litigation Authority (NHSLA), the body responsible for compensating claimants who have been harmed as a result of healthcare treatment, encourages healthcare staff to apologise to service users in this situation and makes it clear that an apology does not constitute an admission of liability. A sincere expression of sympathy and regret made verbally by those providing the care at an

early stage, based on the facts known at the time, should be made even if an investigation is to be instigated and a more formal Being Open/Duty of Candour discussion is to be held with the patient/carers. A delay in saying sorry is often the cause of anger and frustration and is a common reason given for patients seeking medico-legal redress.

Staff should refer to the Claims Handling Policy for further guidance or speak to the Head of Patient Safety Systems, who has lead responsibility for claims management in the Trust.

7. Roles and Responsibilities

7.1 Trust Board

The Trust Board carries corporate responsibility for the strategic management of the organisation's risk in every area and is committed to being open and demonstrating candour. The Trust Board will consider incident information on a regular basis and will require formal notification of any patient safety incident that results in unexpected death or serious harm.

7.2 Quality and Standards Committee

The Quality Committee will seek assurance on behalf of the Trust Board that the principles of this policy are being applied within the Trust's organisation and this will be specifically monitored by the Critical Incident Overview Group.

7.3 Director of Nursing and Quality

The Director of Nursing and Quality is responsible for ensuring that this policy and principles are fully implemented throughout the organisation.

7.4 Delivery Unit Governance Groups

Delivery Unit Governance Groups will monitor the implementation of this policy locally.

7.5 Executive Team and Clinical Directors

The Chief Executive, the Executive Team and Clinical Directors will ensure the principles of this policy are upheld within their areas of responsibility and will personally involve themselves in the resolution of patient safety incidents as required.

7.6 Associate Director for Governance

This post holder is responsible for the implementation, overseeing and reviewing of this policy.

7.7 Head of Patient Safety and Patient Experience

This post holder will provide advice on Being Open and Duty of Candour.

7.8 Patient Advice and Liaison Services (PALS)

The PALS Team will signpost service users, families and carers to the appropriate clinical team for support through the Being Open and Candour process and also signpost advocacy and support agencies that may exist.

7.9 All healthcare professionals and managers

All healthcare professionals and managers must be open and honest with AWP and patients in their care, or those close to them, if something goes wrong (this includes apologising) and

encourage a learning culture by reporting adverse incidents that lead to harm as well as near misses.

7.10 All employees

All employees have a responsibility to contribute to a positive risk management environment and Being Open culture by reporting patient safety incidents, being aware of this policy and actively promoting the Being Open leaflet to service users, carers and families.

8. Standards

This policy has been written in response to a Safer Practice Notice issued by the National Patient Safety Agency on 15 September 2005 and revised following their subsequent update on 19 November 2009. The policy supports the Apologies and Explanation Circular issued by the NHSLA, a copy of which can be found as Appendix 2. This policy is cognisant of the statutory obligations as laid out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the contractual obligations as laid out in the NHS Standard Contract in respect of Duty of Candour.

9. Training

The skill set required to facilitate a Being Open discussion is similar, in many ways, to the skill set required to chair a CPA meeting. As a rule, mental health professionals are accomplished communicators and therefore basic training for staff is not required. Before leading a Being Open discussion for the first time, healthcare professionals require the following support/training:

- The opportunity to act as an observer to a meeting with relatives in potentially contentious situation, e.g., complaints meeting, meeting following an unexpected death or a being open meeting, shadowing a more experienced colleague
- The opportunity to digest and understand this policy
- Supervision from a colleague experienced in conducting such meetings. A list of experienced colleagues is available from the Head of Patient Safety Systems.
- The opportunity to work through the Being open e-learning package on the website of the National Patient Safety Agency.

10. Monitoring or Audit

Compliance with this policy will be monitored through the following mechanisms:

- Regularly, consistently and formally seeking feedback from service users and carers that their expectations have been made, for example through complaints exit surveys.
- Specific annual audits to test requirements have been met.
- Auditing feedback either through commissioning surveys or through file audits at least once every 3 years.
- Providing assurance information as part of the annual incident management report.

11. Definitions

Apology: a sincere expression of regret offered for harm sustained.

Being open: open communication of patient safety incidents that resulted in moderate harm, severe harm or death of a patient while receiving healthcare.

Duty of Candour: a legal obligation to notify patients and families when a notifiable patient safety incident has led to harm.

Carers: family, friends or those who care for the service user. The patient has consented to their being informed of their confidential information and to their involvement in any decisions about their care.

National Reporting and Learning System (NRLS): a confidential and anonymous computer-based system for the collection and analysis of patient safety incident information. It receives incident reports from NHS organisations, staff and contractor professions.

Near miss: see 'Prevented patient safety incident'.

Patient safety incident: any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS-funded healthcare. The terms 'patient safety incident' and 'prevented patient safety incident' will be used to describe 'adverse events' / 'clinical errors' and 'near misses' respectively.

Prevented patient safety incident: any unexpected or unintended incident that was prevented, resulting in no harm to one or more patients receiving NHS-funded healthcare.

Root cause analysis (RCA): a systematic process whereby the factors that contributed to an incident are identified. As an investigation technique for patient safety incidents, it looks beyond the individual concerned and seeks to understand the underlying causes and environmental context in which an incident happened.

Incident Decision Tree (IDT): developed as an aid to improve the consistency of decision making about whether human error or systems failures contributed to an incident. It is designed for use by anyone who has the authority to exclude a member of staff from work following a patient safety incident (including medical and nursing directors, chief executives and human resources staff).

12. Associated and Related Procedural Documents

This policy should be read in conjunction with the:

Incident Policy

Claims Handling Policy

Complaints and Concerns Policy

13. References

The National Patient Safety Agency, Being Open, 1 October 2004

The National Patient Safety Agency, Being open: communicating patient safety incidents with patients, their families and carers, 19 November 2009

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

2015/16 NHS Standard Contract – SC35

14. Appendices

- The Being Open leaflet can be found here
- The NHSLA Circular on Apologies and Explanations can be found here

Version History

Version	Date	Revision description	Editor	Status
2.0	26 March 2009	Board Approval	LDH	Approved
2.0	27 July 2009	Approved by the Quality and Healthcare Governance Committee	LDH	Approved
2.1	04 May 2010	Updated following feedback from Q&HG Committee	LDH	Approved
3.0	6 November 2012	Reviewed and approved by Quality & Safety Committee	LDH	Approved
3.1	6 July 2015	New policy to take account of Duty of Candour requirements scrutinized by Critical Incident Overview Group.	LDH	Draft
4.0	1 September 2015	Policy reviewed and approved by Quality and Standards Committee	LDH	Approved
5.0	19 May 2017	Policy reviewed and administrative changes made to reflect updated organisational structures Approved – review in six months	Associate Director for Statutory Delivery	Approved
5.1	03 December 2018	Marked as under review –extended to July 2019	AM Associate Director of Nursing	Approved