Essex Partnership University NHS Foundation Trust

BEING OPEN AND THE DUTY OF CANDOUR POLICY

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CONSULTATION GROUPS:	Learning Lessons Oversight and Scrutiny Committee, Identified Leads, Community and Mental Health staff
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POLICY SUMMARY

The Trust recognises and acknowledges the importance of openness and good communication between staff and patients, families and carers at all times, not just when things go wrong. This policy and associated procedural guidance aims to ensure that the Trust has an open, honest and consistent approach to communication with patients, relatives, staff or relevant others in the event of any patient safety incident, complaint or claim. The procedural guidance describes the process for acknowledging, apologising and explaining when things go wrong and also outlines the professional, contractual and statutory Duty of Candour to which staff must comply to ensure that when cases of severe or moderate harm occur, patients and relatives are fully informed and involved in the review or investigation process.

The Trust monitors the implementation of and compliance with this policy in the following ways:

The Trust Clinical Governance & Quality Sub-Committee will undertake monitoring of implementation and compliance with this policy and associated procedural guideline.

Services	Applicable	Comments
Trustwide	✓	
Essex MH&LD		
CHS		

The Director responsible for monitoring and reviewing this procedure is the Executive Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

BEING OPEN – DUTY OF CANDOUR POLICY

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

BEING OPEN AND THE DUTY OF CANDOUR POLICY

Assurance Statement

This Policy is intended to provide a robust framework for ensuring an open, honest and consistent approach to communication with patients, relatives, staff or relevant others in the event of any patient safety incident, complaint or claim.

1.0 INTRODUCTION

1.1 Essex Partnership University NHS Foundation Trust (EPUT) is committed to the provision of high quality health care and encourages principles of good practice throughout all services. The Trust recognises that when an incident occurs or when things go wrong resulting in the harm of a patient it is essential that honest and open communication between healthcare teams and patients/families/carers be carried out in a timely and appropriate manner. Ensuring good communication when a patient safety incident occurs is essential and can aid in the prevention of incident recurrence.

1.2 Being Open

The culture of being open should be intrinsic throughout the Trust. It involves:

- Acknowledging, apologising and explaining when things go wrong;
- Conducting a thorough investigation into the incident and reassuring patients, their families and carers that identified learning will help prevent the incident recurring;
- Providing support for those involved to cope with the physical and psychological consequences of what happened.

Promoting a culture of being open in all communication is therefore a prerequisite to providing high quality healthcare and improving patient safety. It is important to remember that saying sorry is not an admission of liability and is the right thing to do.

1.3 Duty of Candour

The Duty of Candour is the requirement for all registered health and social care providers to act in an open and transparent way with people receiving care or treatment from them. The regulation also defines 'notifiable safety incidents' and specifies how providers must apply the duty of candour when these incidents occur.

There are two types of duty of candour – statutory and professional. Both the statutory duty of candour and professional duty of candour have similar aims – to make sure that those providing care are open and transparent with the people using their services, whether or not something has gone wrong.

The Care Quality Commission (CQC) regulates the statutory duty of candour, while the specific healthcare professional regulators such as the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) oversee the professional duty of candour.

The statutory duty includes specific requirements for certain situations known as 'notifiable safety incidents'. If something qualifies as a notifiable safety incident, carrying out the professional duty alone will not be enough to meet the requirements of the statutory duty.

1.4 Saying Sorry

A crucial part of the duty of candour is to apologise. Apologising is not an admission of liability and often it is the lack of a timely apology that leads people to take legal action against providers. To fulfil the duty of candour, the Trust must apologise for the harm caused, regardless of fault, as well as being open and transparent about what has happened.

NHS Resolution is the organisation that manages clinical negligence claims against the NHS – their 'Saying Sorry' leaflet confirms that apologising will not affect indemnity cover:

"Saying sorry is:

- Always the right thing to do
- Not an admission of liability
- Acknowledges that something could have gone better
- The first step to learning from what happened and preventing it recurring."

1.5 Notifiable Safety Incidents

'Notifiable safety incident' is a specific term defined in the duty of candour regulation and should not be confused with other types of safety incidents or notifications.

A notifiable safety incident must meet all three of the following criteria:

1. It must have been unintended or unexpected.
2. It must have occurred during the provision of a CQC regulated activity.
3. In the reasonable opinion of a healthcare professional, already has, or might, result in:
    - the death of the person - directly due to the incident, rather than the natural course of the person's illness or underlying condition
    - led to the person experiencing severe harm, moderate harm or prolonged psychological harm.

2.0 BACKGROUND

Until 2014, there was no legal duty on care providers to share information with people who had been harmed, or their families. In 2013, the Francis Inquiry found serious failings in openness and transparency at Mid Staffordshire NHS Foundation Trust and recommended that a statutory duty of candour be introduced for all health and care providers, in addition to the existing professional duty of candour and the requirement for candour in the NHS standard contract.

This statutory duty of candour was introduced into law in 2014 for NHS Trusts and 2015 for all other providers and is now seen as a crucial, underpinning aspect of a safe, open and transparent culture.

https://www.cqc.org.uk/guidance-providers/all-services/duty-candour-notifiable-safety-incidents

3.0 DEFINITIONS

3.1 Definitions of Harm

Moderate harm
Harm that requires a moderate increase in treatment and significant, but not permanent, harm.

Severe harm
A permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the patient's illness or underlying condition.

Moderate increase in treatment
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 treatment area (such as intensive care).

Prolonged pain
Pain that a patient has experienced, or is likely to experience, for a continuous period of at least 28 days.

Prolonged psychological harm
Psychological harm which a patient has experienced, or is likely to experience, for a continuous period of at least 28 days.

4.0 SCOPE

4.1. This policy applies to all areas of the Trust and all staff involved in providing care and those involved in the investigation of incidents, complaints and claims.

4.2. This policy applies to communication by Trust staff with patients and/or their families/carers (and, where appropriate, other stakeholder organisations) following a notifiable safety incident, complaint and/or legal claim.

4.3. The **statutory** duty of candour applies to all notifiable safety incidents (see section 1.5 for definition).

4.4. The **professional** duty of candour requires all staff to be open and honest with patients and their families/carers when something that goes wrong with their treatment and/or care causes, or has the potential to cause, harm or distress. The requirements of the professional duty of candour are set out in the joint guidelines by the General Medical Council and Nursing and Midwifery Council (see Appendix 5).

5.0 RESPONSIBILITIES

The statutory and professional duty of candour do not apply to any incidents involving harm to members of staff or visitors, however the Trust encourages that in such instances the principles of being open and duty of candour are applied as a matter of good practice.

Chief Executive	The Chief Executive will ensure that this Policy is implemented across the organisation.
Executive Nurse	The Executive Nurse will maintain oversight of the Duty of Candour process and compliance with Regulation 20 requirements.
Executive Medical Director	The Executive Medical Director will ensure that there is effective training and guidance for medical staff in the implementation of this Policy.
Executive Chief Operating Officer	The Executive Chief Operating Officer will ensure that this policy and procedural guidance is embedded into clinical practice and will identify and implement training as appropriate.
Operational Directors and Senior Management	Operational Directors and Senior Managers will implement this Policy within their areas of responsibility through leadership, management systems and example. This will include: • Responsibility for the implementation of this policy when patients are harmed within their directorates.

	• Monitoring the implementation of this policy via clinical audit and supervision. • Ensuring staff receive effective training and that they are competent to implement being open and Duty of Candour principles. • Ensure training records are maintained • Ensure that the Risk Management Team is appropriately notified of all Patient Safety Events. • Be able to evidence that EPUT policies have been followed during any level of investigation.
Learning Lessons Oversight Committee	The Learning Lessons Oversight Committee will: • Ensure there is a measured approach to learning Trust-wide by sharing examples of good practice, and positive outcomes from Being Open/Duty of Candour following patient safety events that occur within the Trust. • Produce a quarterly report to provide assurance to the Board that the principles of Being Open/Duty of Candour are being upheld and that learning from experience is facilitated within the organisation aimed at improving quality of care and safety. • Undertake a regular and systematic analysis of adverse incidents including notifiable patient safety incidents. • Discuss any narrative or statistical information identified through the Being Open/Duty of Candour process about practice, patient or staff safety issues, which may not yet be reported or evidenced from which learning points can be identified and report to the Clinical Governance & Quality Sub-Committee. • Identify new risks emanating from Patient Safety Events that may require a risk assessment and subsequent entry on to the Trust Risk Register as appropriate. • Share learning opportunities with the wider Trust through the governance structure to facilitate changes in practice.
Managers and other Persons in Charge / Team Leaders / Nursing Home Managers	Managers and other persons in charge / team leaders / nursing home managers will: • Ensure the procedures and principles detailed within this policy and associated procedural guidance are followed, documented and monitored to meet all relevant guidance. • Follow this Policy's procedural guidance Section 3.0 "Being Open" Process.

All Staff	All staff must ensure that the principles and processes contained within this Policy and associated procedural guidelines are followed at all times. • Have an awareness of this Policy. • Must ensure that they report all patient safety events, complaints or claims to their line manager immediately. • Have responsibility to ensure as part of continuing professional development they acquire, maintain and disseminate knowledge and skills to carry out where required the principles of being open and the Duty of Candour. • Through, clinical supervision and post incident reviews, can expect to receive support tailored to their individual need.

6.0 KEY PRINCIPLES

6.1 In 2009, the National Patient Safety Agency (NPSA) developed a framework consisting of 10 principles to help organisations create and embed a culture of Being Open. The principles of Being Open are separate to the Duty of Candour requirements, however there is likely to be considerable overlap between the two.

6.2 Ten Key Principles of *"Being Open"*

1. ***Acknowledgement***
   All patient safety incidents should be acknowledged and reported on Datix as soon as they are identified. Where a patient, their family or carers inform healthcare staff that something has gone wrong, they must be taken seriously from the outset, and treated with compassion and understanding by all staff. The person in charge will identify a person to communicate with the patient, relatives and/or carers.

2. ***Truthfulness, Timeliness and Clarity of Communication***
   A nominated appropriate person should give patients, families and carers clear, unambiguous information in a truthful and open manner. This information should not come from different staff, and must not conflict, be unnecessarily complex or use medical jargon that a layperson may not understand.

   What happened should be explained step by step as soon as possible after the incident, based solely on what is known at the time and without making causal or outcome predictions. Staff should explain that new information may emerge from an investigation, and that patients, families and carers will be kept up-to-date. Patients, families and carers should be given a single point of contact for any questions or requests they may have.

3. ***Apology***
   Patients, families and carers should receive a meaningful apology as soon as possible – one that is a sincere expression of sorrow and regret for the harm resulting from a patient safety incident. Delay is likely to increase patient, family and carer anxiety, anger or frustration and no reason justifies it.

   A verbal face-to-face apology is essential as soon as staff become aware of an incident. A written apology must follow clearly stating the organisation is sorry for the suffering and distress resulting from the incident.

4. ***Recognising Patient and Carer Expectations***
   Patients and/or carers should be fully informed of the issues surrounding an incident and its consequences, in a face-to-face meeting with a representative from the Trust. They should be treated sympathetically, with respect and consideration, and provided with support where required to meet their needs such as an independent advocate and or translator. Where appropriate, information on the Patient Advisory and Liaison Service (PALS) and other relevant support groups such as Cruse Bereavement Care should be provided, as soon as possible.

5. ***Professional Support***
   EPUT is committed to providing an environment in which all staff (including those independently contracted) are encouraged to report patient safety incidents. Staff should be supported throughout the incident investigation process because they too may have been traumatised by their involvement. They should not unfairly face disciplinary action, increased medicolegal risk or any threat to their registration. In line with this, EPUT follow the A Just Culture guide when concerns about individuals are raised. These concerns will be managed completely separately from the patient safety incident investigation.

6. ***Risk Management and Systems Improvement***

   Being Open principles are embedded in all EPUT strategies, policies and procedures associated with responding to patient safety incidents. This contributes to an integrated approach to reducing risk and improving patient safety following an incident. The Trust will undertake patient safety incident investigations and reviews in line with its Patient Safety Incident Response Plan and PSIRF Standard Operating Procedure.

7. ***Multi-Disciplinary Responsibility (MDT)***
   Any local policy on openness should apply to all staff who play key roles in patient care. That multidisciplinary teams provide most health care should be reflected in communications with patients, families and carers when things go wrong – to ensure that ‘being open’ is consistent with the philosophy that incidents usually result from system failures and rarely the actions of an individual.

   For ‘being open’ principles to be followed consistently across disciplines, senior clinical, nursing and managerial leaders must support them and model behaviours by participating in incident investigation and clinical risk management. It is important to identify senior managers and senior clinicians to participate in incident investigation and clinical risk

management as per Trust Patient Safety Incident Response Plan, PSIRF Standard Operating Procedure and complaint investigation as per Trust Policy CP2.

8. ***Clinical Governance***
   Findings from investigations and reviews are analysed and disseminated across the Trust so that learning can be understood and embedded. Continuous learning programmes and audits are developed to allow monitoring of the implementation of changes in practice.

9. ***Confidentiality***
   Full consideration in respect of confidentiality and privacy must be appropriately maintained at all times. Consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the patient. The patient, relatives and/or carers will be informed who will be conducting and involved in the investigation before the investigation begins.

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

7.0 PROCEDURAL CONTENT

7.1. Being Open is a process, rather than a 'one off' event and involves a number of stages. The Procedural Guidance documentation attached to this policy covers the following elements of implementation.

7.2. General considerations and foundation principles for Being Open and the Duty of Candour process:

- Incident detection/recognition and immediate actions
- Initial reporting and preliminary team discussions
- The initial discussion with patient/carer
- Investigation process and relevant follow up discussions
- Outcomes/process completion

7.3. The corresponding procedural guidance provides further detail around considering and dealing with specific patient issues/circumstances and the requirements for documenting all communication.

8.0 POLICY IMPLEMENTATION

8.1. This policy will be disseminated across the organisation through the Trust Intranet site.

8.2. In cases where the patients and/or carers inform healthcare staff when something untoward has happened, this must be explored immediately. Any concerns must be treated with compassion and understanding by all healthcare

staff. Denial of patients concerns in any way must be avoided at all costs, as this may make future open and honest communication more difficult.

9.0 POLICY REVIEW AND MONITORING

9.1. The Executive Nurse will ensure that this policy and associated procedural guidelines is reviewed every three years from the date of approval by the Trust Board of Directors.

9.2. An audit to monitor compliance and implementation of the process outlined will be undertaken at this time including as a minimum:

- Process for encouraging open communication between healthcare organisations, healthcare teams, staff, patients and/or their carers
- Process for acknowledging, apologising and explaining when things go wrong
- Requirements for truthfulness, timeliness and clarity of communication
- Provision of additional support as required
- Requirements for documenting all communication

9.3. The results will be presented to the Executive Team and appropriate Trust Committees for appropriate action to be taken.

10.0 ASSOCIATED DOCUMENTS AND GUIDANCE.

10.1. The Trust's documents of Policy and Procedural Guidance associated with this policy are:

- CP2 and CPG2 Complaints Policy and Guidelines.
- CP10 Claims Policy
- CP3 Adverse Incident Policy
- PSIRF Standard Operating Procedure
- EPUT Patient Safety Incident Response Plan
- CL28 Clinical Risk Assessment and Management Clinical Guideline
- CP53 Raising Concerns Policy (Whistleblowing Policy)

10.2. This Trust Policy and Associated Procedural Guidelines is consistent with the following professional and government bodies' guidance:

- Care Quality Commission Regulation 20: Duty of Candour Guidance. 2014, updated 2022.
- National Patient Safety Agency (NPSA), Patient Safety Alert; "Being open", 2009.
- National Patient Safety Agency (NPSA), Being Open Safer Practice Notice, 2005.
- National Patient Safety Agency (NPSA), Being open; communicating patient safety incidents with patients their families and carers. 2009.
- National Patient Safety Agency (NPSA). Seven steps to patient safety. The full reference guide. London. 2004.
- NHS Litigation Authority Apologies and Explanations. Letter to Chief Executives and Finance directors. 2009.
- General Medical Council, Good Medical Practice. 2001
- Nursing and Midwifery Council, The Code: standards of conduct,

performance and ethics for nurses and midwives.
- Department of Health. The NHS Constitution for England. 2009.
- Department of Health, Listening, responding, improving – A guide to better customer care. 2009.

END