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**Contents**

[1 Introduction 3](#_Toc89357500)

[2 Purpose and scope of the policy 4](#_Toc89357501)

[3 Definitions 6](#_Toc89357502)

[4 Ten Principles of Being Open 9](#_Toc89357503)

[5 Duty of Candour process 12](#_Toc89357504)

[6 Fulfilling Being Open process 17](#_Toc89357505)

[7 Homicide 27](#_Toc89357506)

[8 Other considerations 27](#_Toc89357507)

[9 Duties 29](#_Toc89357508)

[10 Policy development, approval and review process 32](#_Toc89357509)

[11 Dissemination and implementation arrangements (including training) 33](#_Toc89357510)

[12 Process for monitoring compliance with this policy 34](#_Toc89357511)

[13 Associated procedural documents and policies 35](#_Toc89357512)

[14 References, related recommendations and links 36](#_Toc89357513)

[Appendix A - Equality Impact Assessment Tool 38](#_Toc89357514)

[Appendix B - Checklist for the Review and Approval of Procedural Document 46](#_Toc89357515)

[Appendix C - Version Control Sheet 48](#_Toc89357516)

[Appendix D - Identifying notifiable safety incidents 49](#_Toc89357517)

[Appendix E - Responding to notifiable safety incidents 50](#_Toc89357518)

# Introduction

South West Yorkshire Partnership Foundation Trust (the Trust) works hard to deliver the highest standards of healthcare to all service users. The promotion of a culture of openness and transparency is a prerequisite to improving patient safety and the quality of healthcare systems. Communication is open, honest and occurs as soon as possible following a patient safety event. This policy reflects the [[1]](#footnote-1)Francis Inquiry Report, the Care Quality Commission (CQC) regulation 20 (a direct response to recommendation 181 of the Francis inquiry report that recommended a Statutory duty of candour be imposed on healthcare providers) and amendments to the NHS Contract in respect of the consequences of not complying with the Duty of Candour.

Francis defines it as “the volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made” and “prompt apologies and explanations, with a reassurance they will not reoccur, may prevent a claim being brought at all’.

This policy describes the process for staff to follow in Being Open and therefore meeting the statutory Duty of Candour. This encompasses communication with service users and/or their carers (if appropriate) and between healthcare professionals, healthcare teams and partner organisations.

Being Open is a set of principles that staff should use when communicating with service users, their families or carers following any incident in which a service user was harmed. Through the NHS standard contract and CQC regulation 20 there are a number of component parts the providers must have regard to. The Trust’s commitment to Being Open is publically supported by the Trust Board.

Being Open means:

* Acknowledging, apologising and explaining what has happened when things go wrong.
* Conducting a thorough review/investigation into the patient safety event and reassuring patients, their families and carers that lessons learned will help prevent the patient safety event recurring.
  + Supporting those involved to cope with the physical and psychological consequences of what happened.

*Being Open* in the Trustissupported by a range of risk management and quality improvement processes, including incident, complaints and claims management, and whistle blowing policies and procedures.

***Being Open context: national guidance and legal context***

Being Open is consistent with recommendations by the NHS and other national organisations including:

* CQC Regulation 20 Duty of Candour[[2]](#footnote-2)
* NHS England Standard Contract - Technical Guidance
* National Patient Safety Agency (NPSA) Being Open Communicating patient safety incidents with patients, their families and carers (2009)
* Seven Steps to Patient Safety 2004(step 5) (NPSA)
* NHS Patient Safety Strategy (2019)[[3]](#footnote-3)

Care Quality Commission (2016) Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England

* National Quality Board (2017) National Guidance on Learning from Deaths
* National Quality Board (July 2018) Learning from deaths - Guidance for NHS trusts on working with bereaved families and carers

Being Open is not an admission of liability and is the right thing to do. Being Open principles are fully supported by a wide range of royal colleges and professional organisations, including the Medical Defence Union, Medical Protection Society and the NHS Litigation Authority.

# Purpose and scope of the policy

## Purpose of the policy

This policy provides a framework for Trust staff to follow in relation to Being Open and in discharging its statutory responsibility for a Duty of Candour following any Notifiable Safety Incident.

## Scope of the policy

The scope of this document is to ensure that patients, their families and carers and staff all feel supported when patient safety events occur or things go wrong. Regulation 20 and its implementation reflect the approach proposed by the [[4]](#footnote-4)Dalton/Williams review, including defining a notifiable safety incident to include moderate harm, severe harm, death, and prolonged psychological harm.

It also aims to improve the quality and consistency of communication. Many services in the Trust are provided on an integrated basis. This joint working is an accepted and respected part of service delivery within the Trust. As members of integrated services, staff from local authorities will play an active role in delivering this policy, make key decisions as part of the process and be involved in Being Open meetings.

## Scope of Being Open

Staff are required to acknowledge, apologise and explain what happened, to service users, their families and carers (taking into account confidentiality and mental capacity considerations) when a patient is harmed as a result of a patient safety event.

In March 2021 the CQC guidance for Duty of Candour was updated to make it clearer what providers must do to meet the requirements of the [CQC regulation](https://www.cqc.org.uk/guidance-providers/all-services/regulation-20-duty-candour) and the circumstances in which it must be applied. It includes introducing three questions to help staff identify a Notifiable Safety Incident, where Duty of Candour will apply. A Notifiable Safety Incident must meet all 3 of the following criteria:

1. It must have been unintended or unexpected.
2. It must have occurred during the provision of an activity CQC regulate.
3. In the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care. This element varies slightly depending on the type of provider.

It also includes some specific actions that providers must take when a Notifiable Safety Incident occurs. See Section 5.

**Failure to comply with this contractual requirement could result in recovery of the cost of the episode of care or £10,000 if the cost of the episode of care is unknown. (NHS Contract)**

And

**It is a criminal offence to fail to provide notification of a notifiable safety incident and/or to fail to comply with the specific requirements of notification. On conviction a health service body would be liable to a potential fine of £2,500. (CQC)**

Staff are not obliged to discuss prevented, ‘no harm’ or ‘low harm’ patient safety incidents with service users, their families and carers. However, where appropriate service users and or their families should be informed as a matter of good practice. These adverse events should still be reported as an incident and evidence of all such communication should be recorded on the incident management system to enable audit to take place.

## Informed consent, confidentiality and effective communication

Being Open needs to take account of concepts that are broadly applicable to all healthcare settings, including informed consent, mental capacity, effective communication and confidentiality.

Consideration must be given to the confidentiality due to all service users, carers and staff (Data Protection Act 2018 and the General Data Protection Regulation) and information disclosure and sharing will be subject to the usual confidentiality and information governance restrictions. Advice can be sought from the Trust Caldicott Guardian.

The Mental Capacity Act 2005 (the Act) aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they’re unable to make important decisions in the future.

The Act applies to anyone aged 16 or over in England and Wales.

If a person lacks the capacity to make decisions, and they have not made advance plans for this situation, the Act allows someone else to make that decision for them. Advice is available on the Trust intranet under mental capacity.

Details of an adverse event should at all times be considered confidential. The consent of individuals concerned will be sought prior to disclosing identifiable information beyond the teams involved in providing care (See 4.9).

## Open fair and just culture

The Trust actively promotes an open, fair and just culture. A culture of openness is one where:

* Staff are open about patient safety events they have been involved in
* Communication is open, honest and occurs as soon as possible following a patient safety event, or when a poor outcome has been experienced
* Staff and organisations are accountable for their actions
* Staff feel able to talk to their colleagues and managers about any patient safety event
* The Trust is open with service users, carers, the public and staff when things have gone wrong, and explain what lessons will be learned
* Staff are treated fairly and are supported when an incident happens

See also the Trust’s policy for Supporting staff involved in traumatic or stressful adverse events.

# Definitions

|  |  |
| --- | --- |
| **Apology** | means an expression of sorrow or regret in respect of a notifiable safety incident |
| **Caldicott guardian** | A senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information sharing. The Guardian plays a key role in ensuring that the organisations responsibilities, and partner organisations satisfy the highest practicable standards for handling patient identifiable information |
| **Candour** | Any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it. |
| **Carer** | A carer is anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. |
| **Duty of Candour** | “the volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made” and “prompt apologies and explanations, with a reassurance they will not reoccur, may prevent a claim being brought at all’. (Francis, 2013)  To ensure that health service bodiesare open and transparent with the “relevant person” when certain incidents occur in relation to the care and treatment provided to people who use services in the carrying on of a regulated activity. |
| **Harm** | Injury (physical or psychological), disease, suffering, disability or death  ***No Harm – it is not a requirement to inform service users and/or family/carers***   * Impact prevented – Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving Trust care.   ***Low Harm – it is not a requirement to inform service users and/or family/carers but could be considered to be appropriate by the clinical team***   * Any patient safety incident that caused minimal harm to one or more service users receiving Trust care – which required extra observation or minor treatment. * *Minor treatment* is defined as first aid, additional therapy, or additional medication. It does not include any continued treatment over and above the treatment already planned, readmission, treatment in Accident and Emergency or admission for medical care.   ***Moderate Harm – it is a requirement to inform service users and/or family/carers***   * Any patient safety incident that caused significant but not permanent harm to one or more service users receiving Trust care, which resulted in a moderate increase in treatment or additional treatment. * *Moderate treatment* *or a moderate increase in treatment* is defined as an unplanned readmission, a prolonged episode of care, treatment at Accident or Emergency or transfer to other care, such as intensive care, as a result of the incident. It includes bone fractures, and might include psychological harm.   ***Severe Harm – it is a requirement to inform service users and/or family/carers***   * Any patient safety incident that appears to have resulted in permanent harm to one or more service users receiving Trust care. * *Permanent harm* means harm directly related to the incident, which is not related to the natural course of the service user’s illness or condition. It includes permanent lessening of bodily functions – sensory, motor, physiological or intellectual, including brain damage, including removal of the wrong limb that is related directly to the incident and not related to the natural course of the service user’s illness or underlying condition.   ***Death – it is a requirement to inform service users and/or family/carers***   * Death resulting from a patient safety incident, not related to the natural course of a service user’s illness or condition.   Where possible, the Being Opendiscussion and any review will occur before the Coroner’s inquest. |
| **Liability** | Legal responsibility for an action or event |
| Notifiable safety incident | Any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in:  (a) the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user’s illness or underlying condition, or  (b) severe harm, moderate harm or prolonged psychological harm to the service user |
| **Openness** | Enabling concerns and complaints to be raised freely without fear and questions raised to be answered. |
| Patient Safety event | In relation to this policy a patient safety event covers complaints, incidents and claims. |
| **Prevented or ‘no harm’ incidents** | Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving Trust care. The Trust encourages staff to report these incidents as part of the Trust’s learning and safety culture. |
| Prolonged psychological harm | Psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days |
| Relevant person (for regulation 20 CQC Duty of candour) | Means the service user or, in the following circumstances, a person lawfully acting on their behalf:  (a) on the death of the service user,  (b) where the service user is under 16 and not competent to make a decision in relation to their care or treatment, or  (c) where the service user is 16 or over and lacks capacity (as determined in accordance with sections 2 and 3 of the 2005 Act) in relation to the matter. |
| Service user | A person receiving care or treatment from Trust services |
| Transparency | Allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. |

# Ten Principles of Being Open

1. Acknowledgement
2. Truthfulness, timeliness and clarity of information
3. Apology
4. Recognition of service user’s and family/carers expectations
5. Staff support
6. Multidisciplinary responsibility
7. Risk management and systems improvement
8. Clinical governance
9. Confidentiality
10. Continuity of care

## Principle of Acknowledgement

All patient safety events should be acknowledged managed and reported (in accordance with the Trust’s incident management policies and procedures) as soon as they are identified.

If a service user, their family or carers inform healthcare staff that something untoward has (or may have) happened, it must be taken seriously. Any concerns should be treated with compassion and understanding. Denial of a person’s concerns will make future open and honest communication more difficult.

Where appropriate, incidents will be reported to external agencies such as the police, through the Vulnerable Adults or the Child Protection procedures.

## Principle of Truthfulness, Timeliness and Clarity of Communication

Information about a patient safety event must be given to service users, their families and carers (taking into account confidentiality considerations):

* In a truthful and open manner by an appropriate person.
* In a timely way – as soon as reasonably practicable after the event is identified and reported on the incident management system.
* They should be provided with a step-by-step explanation of what happened, which considers their individual needs.
* Information given should be clear and unambiguous, avoiding the use of medical jargon and delivered openly.
* Information given must be based solely on the facts known at the time.
* All information should be provided in line with [Accessible Information standards](http://nww.swyt.nhs.uk/Accessible-information-standard/Pages/Accessible-information-standard-.aspx).
* Information given must be consistent – avoid different members of staff giving conflicting information.
* Explain that new information may emerge as an incident is reviewed and that service users, their families and carers will, if they wish, be kept up-to-date with the progress and findings of a review.
* Provide a single point of contact for any questions or requests they may have.

## Principle of Apology

Service users, their families and carers should receive a meaningful apology – a sincere expression of sorrow or regret – as early as possible following harm that has resulted from a patient safety event.

***A verbal apology*** is essential because it allows direct (face to face or telephone) contact between the service user, their family and carers and the healthcare team. This should be given as soon as staff are aware that a patient safety event has occurred where a service user has been harmed. This should be in line with [Accessible Information standards](http://nww.swyt.nhs.uk/Accessible-information-standard/Pages/Accessible-information-standard-.aspx) ensuring the appropriate support for communication is arranged i.e. support from a British Sign Language (BSL), interpreter, deafblind manual interpreter, an advocate or community language.

The service manager or most senior person on duty should decide on the most appropriate member of staff to give this verbal apology. A more senior service or on-call manager may need to be consulted regarding this decision, which should consider seniority, relationship to the patient, and experience and expertise in the type of patient safety event that has occurred.

Delays in giving this apology may increase the service user, family or carers’ sense of anxiety, anger or frustration.

Please refer to additional guidance in the [Learning from Healthcare Deaths](file://swyt-fhh-fs02.xswyt.xswy.nhs.uk/home_drives/helenro/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/AAVP2NQZ/Learning%20from%20Healthcare%20Deaths) policy. See Section 5 for further details.

**Saying sorry is not admitting fault**

A crucial part of the duty of candour is the apology. Apologising is not an admission of liability. This is the case, regardless of whether you are in the health or social care, or public or private sectors. In many cases it is the lack of timely apology that pushes people to take legal action. [Saying sorry is not admitting fault](https://www.cqc.org.uk/guidance-providers/all-services/regulation-20-duty-candour#say-sorry) To fulfil the duty of candour, you 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](https://resolution.nhs.uk/resources/saying-sorry/) 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.

## Principle of recognising service user and family/carer expectations

Service users, their families and carers can reasonably expect to be fully informed of the issues surrounding a patient safety event, and its consequences, in a meeting with representatives from the Trust. They should be treated sympathetically, with respect and consideration, and offered support in a manner appropriate to their needs.

If a service user and/or their carers inform Trust staff that something untoward has happened, it must be taken seriously and treated with compassion and understanding by all Trust staff from the outset.

Information that emerges during a review, investigation or subsequent to the initial explanation must be offered to patients and their carers/families as soon as is practical. It is helpful to establish regular updates with affected individuals. Any incident investigation reports must be shared as soon as possible after being signed off ascompleteby the Directors on behalf of the Board. This includes action plans and the actual written reports and, if necessary, plain English explanations of their contents. The Trust should ensure that verbal and written feedback of reviews is provided in line with the [Accessible Information standards](http://nww.swyt.nhs.uk/Accessible-information-standard/Pages/Accessible-information-standard-.aspx).

Support such as an independent advocacy or a translator may need to be considered. Where appropriate, information about the Trust’s Customer Services and support groups, should be given as soon as it is possible.

## Principle of staff support

The Trust recognises that staff may be affected by a patient safety event and aims to provide appropriate support (see Supporting staff following a traumatic or stressful adverse event policy). Using the [Just Culture guide](https://improvement.nhs.uk/documents/2490/NHS_0932_JC_Poster_A3.pdf)[[5]](#footnote-5) can help to ensure a robust and consistent approach to patient safety event reviews.

Where there is reason for the Trust to believe a member of staff may have committed a criminal act it will take appropriate action through the Trust’s disciplinary and other processes, and advise the member(s) of staff of this at an early stage, to enable them to obtain separate legal advice and/or representation.

## Principle of multidisciplinary responsibility

Most care provision in the Trust is through multidisciplinary teams. This should be reflected in the way that service users, their families and carers are communicated with when things go wrong, to ensure that the Being Open process is consistent with the philosophy that patient safety incidents usually result from systems failures rather than from the actions of an individual.

To ensure multidisciplinary involvement in the Being Open process, support and advice to staff in Being Open with service users and families and carers, is through the service management structure and, out of hours, through the on-call manager. Support can also be obtained from the Medical and Nursing, Quality and Professions directorates.

## Principle of risk management and systems improvement

Being Open is one part of the Trust’s integrated approach to improving patient safety following a patient safety event, which is supported by the incident, complaints, claims and risk management policies and processes. All adverse events are investigated and reviewed using the tools and/or principles of systems analysis to identify any learning. The Trust supports an open, fair and just culture, and encourages staff to report all patient safety incidents.

## Principle of clinical governance

Being Open is an integral part of clinical governance and quality improvement; processes are in place to review, investigate and learn from adverse events and service user experience. The Trust has a system of accountability in place, through the responsible Director and Non-Executive Director, Operational Management Group, the Clinical Governance and Clinical Safety Committee and the Trust Board.

## Principle of confidentiality

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

Communications with parties outside of the clinical team should also be on a strictly need-to-know basis and, where practicable, records should be anonymous.

It is good practice to inform the service user, their family and carers about who will be involved in a review before it takes place, and give them the opportunity to raise any objections.

## Principle of continuity of care

Service users 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 service user expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made for them to receive treatment elsewhere.

Consideration will also be given to contacting other Trust teams and staff, the GP and other services or agencies involved in providing care to the individual – these services may be able to offer support to the service user and/or their family/carers at a difficult time.

# Duty of Candour process

In March 2021 the CQC guidance was updated to make it clearer what providers must do to meet the requirements of the [CQC regulation](https://www.cqc.org.uk/guidance-providers/all-services/regulation-20-duty-candour) and the circumstances in which it must be applied. It also includes some specific actions that providers must take when a notifiable safety incident occurs.

The Trust produced a guidance document to detail the new requirements which was initially available as a procedure on the [duty of candour intranet pages](https://swyt.sharepoint.com/sites/Intranet/incident-reporting/Pages/Duty-of-Candour.aspx). This is now incorporated below but should be read with the CQC regulations.

## Statutory and professional duties of candour

The Duty of Candour is a general duty to be open and transparent with people receiving care from the Trust. There are two types of Duty of Candour - statutory and professional. This update refers to the statutory duty of candour. Professional bodies (eg GMC, NMC, AHP bodies) oversee the professional responsibilities of individuals.

## Saying Sorry

A crucial part of the Duty of Candour is the apology. Saying sorry is not admitting fault or liability.

People are sometimes uncertain about how to apologise when an incident is still being investigated. But from the start, simple straightforward expressions of sorrow and regret can and should be made for the harm the person has suffered.

In many cases it is the lack of timely apology that pushes people to take legal action. To fulfil the duty of candour, we 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’](https://resolution.nhs.uk/resources/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.

## Notifiable Safety Incidents

A ‘notifiable safety incident’ is a specific term defined in the CQC duty of candour regulations. The guidance on what sets out new criteria to help with identifying if an incident is a notifiable safety incident which then meets the threshold for duty of candour.

A notifiable safety incident must meet all 3 of the following criteria:

|  |  |  |
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| **Questions to determine if this is a notifiable safety incident (adapted from CQC regulations)** | **Answer** | **Comments** |
| 1. Was this incident unintended or unexpected? | Yes/No |  |
| 1. Did this incident occur during the provision care to a SWYPFT patient whilst under the care of (or related to) a Trust service regulated by the CQC? | Yes/No | Most patient safety incidents resulting in moderate or severe harm or patient safety related death will occur whilst under the care of community or inpatient services, which are regulated by the CQC. The Trust may not have been present at the time of the incident. |
| 1. In the reasonable opinion of a healthcare professional, has or might this incident result in moderate harm, severe harm, prolonged psychological harm or death to a patient as a result of a SWYPFT patient safety incident whilst receiving care from the Trust? | Yes/No | See definitions for moderate harm, severe harm and patient safety related death below. |
| 1. Has Yes been answered to all three questions above to identify a Notifiable Safety Incident? | Yes/No | This answer will be used to identify Notifiable Safety Incidents. |

The three questions (1-3 above) have been added to Datix to prompt responsible managers with identifying notifiable safety incidents.

A further question (4) has been added to Datix, to ask whether the three questions above are all answered yes, and therefore overall the incident is a Notifiable Safety Incident. This field on Datix is used for reporting purposes for applicable incidents for Duty of Candour.

For question 3, regarding the level of harm caused, these are defined as incidents that:

* Resulted in the death of the person - directly due to the incident, rather than the natural course of the person’s illness or underlying condition (deaths should still continue to be reported in line with the [Learning from healthcare deaths policy](https://swyt.sharepoint.com/sites/Intranet/learning-from-deaths/Pages/default.aspx) and contact should be made with families and carers)
* Led to the person experiencing severe harm or moderate harm (see definitions of [degree of harm](http://nww.swyt.nhs.uk/incident-reporting/Pages/Degree-of-harm-explained.aspx) below. Also refer to the [Incident Reporting and Management policy](http://nww.swyt.nhs.uk/docs/Documents/425.doc))
* Led to the person experiencing prolonged psychological harm which the service user has experienced, or is likely to experience, for a continuous period of at least 28 days

**Degree of harm definitions:**

The Trust grades incidents in two ways.

The Degree of Harm is used by all Trusts to grade the actual level of harm to ensure consistency of recording nationally. When staff report incidents, they will complete the Degree of Harm to rate the actual harm caused by the incident. Where this is not yet known, they will rate this as what they expect the harm level to be. It will be reviewed and updated at a later point. This differs from the incident severity (green, yellow, amber, red), which is how we grade incidents locally in the Trust. Incident severity takes into account actual and potential harm caused and the likelihood of reoccurrence (based on the Trust’s risk grading matrix).

Our Patient Safety incidents are submitted to NHS Improvement via the National Reporting and Learning System (or equivalent) with a degree of harm. We also use the Degree of harm to determine which patient safety incidents meet the threshold for Duty of Candour (moderate and above):

|  |  |
| --- | --- |
| No harm | Any incident that had the potential to cause harm but was prevented, resulting in no harm OR any incident that ran to completion but no harm occurred to the individuals involved. |
| Low harm | Any incident that required minor treatment or extra observation and caused minimal harm to one or more individuals. |
| Moderate harm | Any incident that resulted in moderate increase in treatment or intervention which caused significant but not permanent harm, to one or more individuals. |
| Severe harm | Any incident that resulted in permanent, significant or long term harm to one or more individuals. |
| Patient Safety related death | Any incident that directly resulted in the death of one or more patients. |
| Prolonged Psychological harm | Psychological harm which an individual has experienced, or is likely to experience, for a continuous period of at least 28 days. |

Appendix D is a flowchart to assist with identifying a ‘notifiable safety incident’.

CQC have provided some [examples](https://www.cqc.org.uk/guidance-providers/all-services/duty-candour-examples-notifiable-safety-incidents).

## Responding to identified notifiable safety incidents

The Duty of Candour procedure must be started ‘as soon as reasonably practicable’. CQC will always expect to see providers acting promptly as soon as a notifiable safety incident has been discovered. Appendix E has been developed to set out the steps that need to be taken.

The responsibility to ensure duty of candour is undertaken sits with the leaders of the organisation. In SWYPFT this should be team managers, supported by Quality and Governance leads, practice governance coaches and matrons. They should liaise with the relevant person (either the person who was harmed or someone acting lawfully on their behalf).

The regulation states that we must:

1. Tell the relevant person, face-to-face, that a notifiable safety incident has taken place (if face-to-face is not possible, record the reason why)
2. Apologise.
3. Provide a true account of what happened, explaining whatever we know at that point.
4. Explain to the relevant person what further enquiries we believe to be appropriate.
5. Follow up by providing the above information, and the apology, in writing, and providing an update on any enquiries\*
6. Keep a secure written record of all meetings and communications with the relevant person.

\*To clarify point 5 above, local practice has been to offer to send or give a letter after the verbal apology, which was often declined. This is no longer suitable, and we should always follow up in writing to the relevant person. There may be some exceptions where it may be agreed by the MDT that a letter would not be clinically advisable, and this decision should be clearly documented.

## Reasonable support

Throughout the process we must give ‘reasonable support’ to the relevant person, both in relation to the incident itself and when communicating with them about the incident. ‘Reasonable support’ will vary with every situation, but could include, for example:

* environmental adjustments for someone who has a physical disability
* an interpreter for someone who does not speak English well
* information in accessible formats
* signposting to mental health services
* the support of an advocate
* drawing their attention to other sources of independent help and advice such as AvMA (Action against Medical Accidents) or Cruse Bereavement Care.

If the relevant person consents, it is expected that we have involved family members and carers in any discussions.

It is about taking reasonable steps to make sure we communicate in a way that is as accessible and supportive as possible.

If the relevant person cannot be, or refuses to be, contacted, we may not be able to carry out points 2 to 4 above (apologising, providing a true account of what happened, and explaining what further enquiries we believe are appropriate), therefore we must keep a written record of all attempts to make contact. We must still report the incident and review/investigate it in order to prevent harm occurring to others.

## Incidents not meeting the threshold

Where an incident does not meet the 3-question threshold above, and is not then a Notifiable Safety incident, the Trust’s Being open principles still apply (see sections in this policy) and the [Learning from Healthcare Deaths policy](https://swyt.sharepoint.com/sites/Intranet/learning-from-deaths/Pages/default.aspx) (communicating with bereaved families/carers).

## Further guidance and support

Each BDU should have an identified lead for Duty of Candour advice and support. This is often the Quality and Governance lead, Matron or Practice Governance Coach. They should be contacted in the first instance.

The Patient Safety Support Team can also offer guidance to the above via [risk@swyt.nhs.uk](mailto:risk@swyt.nhs.uk)

# Fulfilling Being Open process

Being Open is a staged process rather than a one-off event. The extent and duration of the process will depend on the adverse event, the needs of the service user, their family and/or carers, and how the review progresses. Being Open in relation to complaints which do not relate to a patient safety incident will follow the complaints process.

## Documenting the Being Open process

Throughout the Being Open process it is important to keep records of any contacts and discussions with the service user, their family and carers. This will include:

* A record of all meetings including:
* The date, time, place, names, roles, relationships of those who attended
* What the discussion covered and any actions agreed
* Questions raised by the service user/ families/carers and the answers given.
* Offers of assistance and the service user and/or carers response.
* The plan for further communication and contact.
* A summary of agreed action plans.
* Providing the service user and/or carer with a written summary of any meetings in relation to the incident, including agreed actions.
* Copies of letters sent to service user, carers and other parties e.g. the GP.
* File notes of any other communication such as telephone discussions.

These Being Open records will usually be kept securely in a record separate from but cross referenced to the service user’s care record. Location of such records will be recorded on the incident management system. Documents can be uploaded to Datix and stored with the incident.

## Summary of stages of Being Open process

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Stage 1** | **Stage 2** | **Stage 3** | **Stage 4** | **Stage 5** |
| **Patient safety event detection and management** | **Inform service user/carer as soon as reasonably practicable**  **(Duty of Candour)** | **Planning further Being Open process** | **Being Open meeting/ discussion** | **Being Open process completed** |
| **Prompt care and actions to prevent any further harm**  **Incident reporting**  **Identify staff and service user support needs** | **Provide open honest factual information**  **Offer initial verbal apology / expression of regret**  **Offer initial support**  **Discuss further contacts**  **Follow up in writing** | **Establish the facts**  **Decide the process**  **Identify lead person**  **Agree who will meet with who when and where**  **Identify support needed** | **Explain the process**  **Offer further apology and support**  **Provide factual details**  **Explain learning process**  **Invite questions / comments**  **Agree any further contact**  **Follow up in writing**  **Keep in touch as agreed at meeting** | **Feedback from the review process, learning and actions to service users and/or carers**  **Follow up in writing**  **Feedback to other Trust staff and partners** |
| **No Being Open process required for near miss or no harm incidents**  **Keep written records**  **of all *Being open contacts***  ***and discussions:***   * **When** (date/time) * **Who Who** was involved * **What** information was given by who * **Remember to write to relevant** * **person with summary of** * **meetings and outcomes** | **End of the Being Open process for low harm incidents**  **or if family decline contact** |  | **May be end of Being Open process or may agree further contact** | **End of Being Open process** |
| **Documentation** |  |  | **Record incident review process, location of evidence *and***  **learning outcomes on the Datix incident record** |  |

## Being Open - stages

**Stage 1: Patient safety event detection or recognition and management (including notifiable patient safety incident)**

The Being Open process begins with the recognition that a service user has been harmed as a result of a patient safety incident. This may be identified by:

* Staff at the time of the incident;
* Staff retrospectively when an unexpected outcome is detected;
* A service user, their family or carers who express concern or dissatisfaction with the service user’s healthcare either at the time or retrospectively;
* Incident detection systems - such as incident reporting or case record review;
* Other sources - such as detection by other service users, visitors or non-clinical staff

As soon as a patient safety incident is identified, the top priority is prompt and appropriate clinical care and prevention of further harm.

The Trust’s incident management and/or complaints processes should then be implemented, including incident reporting.

Identify immediate support needs for staff involved (see Supporting Staff Policy).

If the patient safety incident occurred in another organisation that organisation will be alerted on a colleague to equivalent colleague basis. The Being Open process and the review and analysis of the patient safety incident will usually take place in the organisation where the incident took place.

**Stage 2: Inform/contact service users and/or carers**

Following a patient safety incident where a service user has been harmed, the relevant team will contact the service user and/or (where appropriate) any family/carer as soon as reasonably practicable (no more than 10 working days) to:

* Inform them about the incident openly and honestly
* Offer an initial verbal apology/expression of regret (face to face if possible)
* Offer initial support
* Discuss further contact arrangements

Where a death has occurred, the guidance in the [Learning from Healthcare Deaths](file://swyt-fhh-fs02.xswyt.xswy.nhs.uk/home_drives/helenro/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/AAVP2NQZ/Learning%20from%20Healthcare%20Deaths) policy should be followed which includes the following points to take into account during the initial contact with the family of a deceased service user:

* offer condolences
* obtain a name and contact details for the family member
* sensitively ask about the circumstances and cause of the death
* ask if they have any questions about the care their family member received from the Trust
* offer support and signpost to sources of support, e.g. GP, third sector organisations etc.

It will usually be more important to tell the service user and/or carer about the incident as soon as possible rather than to wait for one particular member of staff to be available. The decision on who should give the information will need to take into account:

* the seriousness of the incident
* the degree of harm or injury
* relationship to the service user,
* seniority, experience and expertise
* involvement in the incident
* availability

Following the initial Being Open meeting with the service user and/or their family/carers a summary of the meeting will be sent to them – either in the form of a letter which includes a written apology/expression of regret.

***Written apology***

A decision should also be taken who will write a letter of apology and/or expression of regret. This decision and who should provide this written apology will be made at general manager/practice governance coach, clinical lead level in consultation with the team manager and/or director, as appropriate to the individual case.

If the service user and/or family or carer decline to meet with staff at this stage and a letter of apology has not already been sent, then at this stage a letter of apology including an offer of support, contact and an explanation of Trust processes should be sent from the BDU service line management.

*A written apology* must be provided by the Manager, as follows:

Moderate harm or serious harm: In cases where moderate or serious harm has occurred as a result of a patient safety incident a letter should be written in a timely way, but a judgement will need to be made about the appropriate time for this letter to be sent. This will depend on other Being Open arrangements.

Death of a service user (whether as a result of a patient safety incident or not): The manager should write a timely letter of condolence and regret to the family or carer following the unexpected death of someone in contact with mental health services, at the time of their death, or in the previous 6 months. This contact will depend on circumstances, confidentiality and the known involvement of any family/carers in the service user’s care and life. This letter should include:

* Condolences for the death;
* The below points should be covered in the communication, but will also be available in a separate leaflet that should be enclosed with the communication.
  + an explanation of how families can comment, ask questions or raise concerns about their relative’s care through the team manager or through the customer services team (further details will be included in a leaflet). The Trust needs to understand what families want to know, so these areas can be included in investigation terms of reference.
  + if they raise significant concerns, this would automatically prompt a review of the care received (further details will be included in a leaflet)
  + An overview of how we review the care of those who have died whilst under our care.
  + information about local and/or national bereavement support available to families (further details will be included in a leaflet)
* The content should be approved by a manager.

(refer to Learning from Healthcare Deaths policy).

**For less severe incidents and deaths unrelated to patient safety where no concerns have been raised, this will be the end of the Being Open process.**

It is not a requirement to inform service users or family/carers of no harm or near miss incidents where no actual harm occurred, but in some cases services may decide that it is appropriate to do so, eg low harm incidents.

**For more serious incidents (notifiable safety incident)** the *Being Open* process is not usually a one-off event and regular follow-up meetings may be arranged to ensure the service user and/or carers are kept updated where appropriate. Wherever possible the Trust contact will remain the same, but other representatives may be involved as well if this is helpful e.g. the Lead Investigator.

The lead contact person will liaise with the Legal and Complaints Departments to avoid confusion and duplication if formal procedures are instigated. The principles described for the initial meeting apply throughout the whole B*eing Open* process.

This initial contact is likely to be followed up by or take the form of a more formal meeting with the service user and/or carer/s to discuss what has happened, to provide information and offer a more formal apology. This process is described below.

If contact cannot be made or a decision has been reached not to contact family/carers this must be documented, clearly describing the reasons why contact has not be made, the rationale for this decision and who was involved in the discussion. This must be communicated to the Assistant Director Patient Safety who has delegated responsibility for reporting exception to the commissioning body.

**Stage 3: Plan the Being Open process and engagement with the service user and/or family/carers**

Where a patient safety incident has led to a service user sustaining moderate or severe harm or injury or death (usually amber and red incidents) the full Being Open process will usually be followed. The first Being Open discussion with the service user and/or their family and/or carers should take place as soon as reasonably practicable (no more than 10 working days) from recognition of the patient safety incident.

As soon as possible after the incident the multidisciplinary team, including the most senior health professional involved, and in consultation with the Senior Manager should:

* Establish the basic clinical and other facts – recorded on Datix in the Serious Incident Managers 48 hour review section.
* Assess the incident to determine the appropriate Being Open response; the level of response depends on the nature of the patient safety incident.
* Identify who will be responsible for contact and discussion with the service user and/or their family and/or carers.
* Consider appropriate service user/carer support at this early stage – such as the use of a facilitator, advocacy services or a healthcare professional who will be responsible for identifying the service user’s/carers needs and communicating them back to the healthcare team.
* Ensure there will be a consistent approach by all team members around discussions with the service user and/or their family or carers.

1. ***Factors to consider when timing this discussion/communication***:

* Clinical condition of the service user;
* Service user/carer preference (in terms of whether, when and where the meeting takes place and which staff member leads the discussion);
* Privacy and comfort of the service user/carer;
* Availability of key staff
* Availability of support staff, for example a translator or independent advocate;

1. ***Meeting or communicating with the service user and/or their carers about a patient safety incident:***

This can be anyone that the service user is familiar with, but usually the most senior person responsible for the service user’s care. It is recommended that where possible at least two staff members meet with the service user and/or carer. In some cases it may be appropriate for this to be a senior representative of the Trust.

Where possible the meeting will include someone who:

* Is known to, and trusted by, the service user and/or their carers.
* Has a good understanding of the facts relevant to the incident.
* Has sufficient credibility, seniority, experience and expertise for service users, carers and colleagues to feel confident that matters will be appropriately addressed.
* Is able to communicate with service users and carers in a way they can understand, avoiding use of health service and medical jargon.
* Be willing and able to offer an apology, reassurance and feedback to service users and carers.
* Where possible will be able to maintain a medium to long term relationship with the service user and/or their carers, to provide continued communication and information.
* Be culturally aware and informed about the specific needs of the service user and/ or their carers.

1. ***Involving others***
2. With the service user’s agreement, carers and/or those close to the service user can be included in the discussions and decision making. If the service user is unable to participate or has died, then the carers or people closely involved with the service user may be provided with limited information in order to make decisions, but this should be done with regard to confidentiality and any service user instructions.
3. Junior staff or those in training may be involved in but not usually lead the Being Open process except when all of the following criteria have been considered:

* The incident resulted in low harm.
* They have expressed a wish to be involved in the discussion with the patient, their family and carers.
* There is a senior healthcare professional or manager present or available for support.
* The service user and/or their family and carers do not object.

1. In cases where the healthcare professional who has made an error which may have led to the patient safety incident wishes to attend the Being Open discussion to apologise personally:

* If there are service user and/or carers attending, they will be accompanied and supported by an experienced staff member who will lead the process
* If the service user and/or family/carers prefer this staff member not to be present, a personal apology from that person could be given to the service user and/or their family/carers during the first *Being Open* discussion.

**Stage 4: Being Open meetings/discussion**

A written record of any meetings should be prepared and shared with the service user, and/or their family, carer and/or advocate. It may be useful to include/identify someone to minute the meeting, or to record and transcribe the meeting.

1. ***Conducting the meeting***

* Avoid:
* Speculating about what happened – only provide known facts
* Attributing blame
* Denial of responsibility
* Providing conflicting information from different individuals
* If for any reason it becomes clear during the initial discussion that the service user or family/carer would prefer to speak to a different staff member or health professional, these wishes will be respected.
* Some service users and/or family/carers may not wish to know every detail of an incident at this point in time. They need to be reassured that if they change their minds at a later date this information will be made available to them.

1. ***Content of the initial Being Open discussion***

* Make introductions.
* Refer to the adverse event and provide an expression of genuine sympathy and an apology/expression of regret for what has happened.
* Explain the purpose of the meeting and suggest a meeting structure/plan.
* Invite any immediate questions or concerns to be raised.
* Explain the known facts as agreed by the multidisciplinary team.
* If known, explain what went wrong and where possible, why it went wrong. (If there is disagreement or uncertainty, communication about these events will need to be deferred until after the review has been completed. This will be explained.)

* Information on likely short and long term effects of the incident (if known). This may also have to be delayed to a subsequent meeting when the situation becomes clearer.
* If appropriate give an explanation about what will happen next in terms of the long term treatment plan.
* Explain if the cause of death is unclear pending a Coroner’s Inquest.
* Give the service user and/or family/carers an opportunity to ask questions.
* Ask the service user and/or family/carers why they thought the incident occurred and any concerns they may have.
* What actions the Trust intends to take including an explanation of the review process (see section c below). It may be appropriate to share and discuss the draft Terms of Reference, which can be amended to include any issues raised at the meeting.
* Show that service user’s and/or family/carers views and concerns have been heard and will be taken seriously - reflect them back and record them. Where appropriate ensure these are fed into the Terms of Reference for the investigation process.
* Offer support (see section d below)
* Provide a contact for future communication.
* Agree how and when there will be further communication, such as a further meeting or a time when there will be a further contact.
* Reassure the service user and/or family/carer that they will continue to be treated according to their needs, even in circumstances where there is a dispute between them and the care team, or if a complaint or claim has been made.
* If the service user has lost confidence in the healthcare team involved in the patient safety event it should be explained that they have the right to continue their treatment elsewhere, and that if possible appropriate arrangements will be made for this.

1. ***Provide Information about the review process***

Explain to the service user and/or their family/carers:

* That the Trust is taking the issue very seriously, and that there will be (or has been) an internal review to identify any areas for improvement and learning.
* That this is in accordance with Trust policy and that new facts may emerge from this process.
* The review process.
* The draft terms of reference for the review.
* That they will be given opportunity to receive feedback on the outcome and findings of the review and what actions the Trust intends to take to address any service failures.
* If another investigation supersedes the incident review – such as a safeguarding process, police investigation, or disciplinary process. The reason for this will be explained.

1. **Offering support and a contact person:**

The service user and/or family/carer will be given the contact details of one member of staff who will act as a contact point and potential support for them.

An offer of practical and emotional support will also be made. This may involve giving information on third parties such as charities and voluntary organisations, and/or offering more direct assistance.

It may also be appropriate to provide information on the Trust’s Customer Services Team for assistance should they wish to make a complaint or discuss a concern they may have.

A written record of any meetings should be prepared and shared with the service user, and/or their family, carer and/or advocate.

**Stage 5: Completing the process: feedback from the review/investigation**

Feedback from the incident review or complaints investigation will usually be offered to the service user and/or their family/carers. This must be within 10 working days of the report being signed off as complete and the review/investigation closed by the Commissioners. How this is done will be agreed by/with the individuals concerned. The feedback will usually include an explanation of:

* The purpose of the review (to find out what happened and why, to learn and prevent recurrence).
* What was done to review the incident.
* Relevant facts and a summary of any factors that contributed to the incident/event.
* What has been done to address the service user’s and/or carers concerns or complaints.
* The overall findings and recommendations of the report.
* Information on what has been and will be done to avoid recurrence of the incident and how improvements will be monitored.
* A repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the incident.

It may also be relevant to ask if the service user, family and/or carer would like to be updated on action plan implementation and improvements.

1. ***Withholding or restricting information***

In *exceptional* cases information may have to be withheld or restricted e.g. information that could adversely affect the health of the service user; where other investigations are pending; where confidentiality may be breached; where specific legal requirements preclude disclosure for specific purposes. The service user/carer will be informed of the reasons for any information being withheld.

The only circumstances in which it is appropriate to withhold patient safety incident information (other than as described above) from a mentally ill service user will be when the Consultant Psychiatrist feels it would cause adverse psychological harm to the person, or where there are mental capacity issues (see 2.4). This would be a rare circumstance and a second opinion (by another Consultant Psychiatrist) would be needed to justify withholding information from the service user.

## Providing information about and involvement in the Trust’s internal review process

It is important that in appropriate cases any carers/family are made aware of the Trust’s internal review process and given an offer of involvement in this process. It may or may not be appropriate to give this information at the first contact, and some families/carers may not want any further involvement – although the offer of a future contact can be given if they change their minds.

If involvement is wanted, it may be appropriate for the Senior Manager and/or lead investigator to meet with family and carers to share the terms of reference for the internal review and/or discuss their perspective on what has happened and any concerns they may have.

In appropriate cases carers/family should be given the opportunity to hear what the findings of the internal review were. There are a number of ways this might be done, and this needs to be carefully considered for each individual case and take into account the needs of the family/carers. This should be offered in a timely way, as soon as possible after the review and report are completed and where possible should be done in a supportive face-to-face meeting. The findings might be shared by the Senior Manager and/or the General Manager and/or the lead investigator, and/or the care coordinator.

## If service users and/or carers do not agree with the information provided

If service users and/or carers do not agree with the information provided staff will try to resolve these concerns through discussion and explanation. Sometimes, despite the best efforts of staff, the relationship between the service user and/or their carers and the nominated staff breaks down. The following strategies may assist:

* Deal with the issue as soon as it emerges.
* With the service user’s agreement, involve their family/carers in discussions from the beginning.
* Ensure the service user has access to support services or advocacy services
* Agree and prepare a written list of the points that the service user and/or their family/carer disagree with and reassure them you will follow up these issues.
* Offer the service user and/or their family/carers a different contact person with whom they may feel more comfortable. This could be another member of the team or the individual with overall responsibility for Patient Safety.
* Consider using a mutually acceptable mediator to help identify the issues between the Trust and the service user to look for a mutually agreeable solution.
* Ensure the service user and/or their family/carers are fully aware of the formal complaints procedures.

## Communication with other Trust staff, health and social care teams, organisations, and agencies and service users and/or their carers

Consideration will also be given to contacting other Trust teams and staff, the GP and other services or agencies involved in providing care to the individual:

* These services may be able to offer support to the service user and/or their carers at a difficult time.
* It may be necessary to include these services in any review.
* It may be appropriate to share outcomes and learning.

See also Supporting staff involved in traumatic or stressful adverse events policy.

# Homicide

There are rare occasions when a mental health service user is the perpetrator of an alleged homicide.

In these cases decisions about the formal Being Open process will usually be taken at Director level. However the care team may inevitably have early contact with the service user.

Where a service user is alleged to have committed a homicide, the Being Open process needs to be considered not only for the service user and his/her family/carers but also for the victim’s family/carers. The circumstances of each case will be different and decisions will need to be taken on a case by case basis taking into account the considerations listed in section 7, and also police involvement.

Sometimes offers of contact with the victim’s family will be through the police. They could also be invited to contact [Hundred Families organisation](http://www.hundredfamilies.org/) who may make contact on their behalf.

In many cases in will be appropriate and good practice to follow up any personal contact with a more formal letter of condolence, an expression of regret and offer of support. This letter will usually be sent by the senior manager and include information about the internal review and learning process (see 4.2).

# Other considerations

## Media interest

All enquiries from the media should be directed to the Trust’s Communications Team.

## Legal proceedings

If legal proceedings are underway advice should be sought from the Trust’s Legal Team.

## Service users who have a cognitive impairment and may lack mental capacity

Wherever possible a service user who has a cognitive impairment and may lack mental capacity will be involved in communications about what has happened. An advocate with appropriate skills should be available to the person to assist in the communication process.

Some service users may have authorised a person to act on their behalf by an enduring power of attorney. In these cases steps must be taken to clarify the extent of this authority and the *Being Open* discussion would be held with the holder of the power of attorney. If a person lacks the capacity to make decisions, and they have not made advance plans for this situation, the Act allows someone else to make that decision for them. Where there is no such person, staff may act in the service user’s best interest in deciding who the appropriate person is to discuss incident information with, regarding the welfare of the service user as a whole and not simply their medical interests. Advice is available on the Trust intranet under mental capacity.

## Service users with a different language or cultural considerations

The need for translation and advocacy services, and consideration of special cultural needs (such as for service users 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 interpreter before the meeting on the most sensitive way to discuss the information. Avoid using ‘unofficial translators’ and/or the service user’s family or friends as they may distort information by editing what is communicated. The Trust policy [Interpreting, Translating and Transcribing](file://swyt-fhh-fs02.xswyt.xswy.nhs.uk/home_drives/helenro/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/AAVP2NQZ/Interpretation,%20translation%20and%20transcription%20policy) will provide guidance for staff.

## Service users with different communication needs

Some service users 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 service user is essential to facilitating a process, focusing on the needs of individuals and their families and being personally thoughtful and respectful. All communication and information should be provided in line with [Accessible Information standards](http://nww.swyt.nhs.uk/Accessible-information-standard/Pages/Accessible-information-standard-.aspx).

The Trust policy [Interpreting, Translating and Transcribing](file://swyt-fhh-fs02.xswyt.xswy.nhs.uk/home_drives/helenro/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/AAVP2NQZ/Interpretation,%20translation%20and%20transcription%20policy) will provide guidance for staff.

## Children

The Trust’s Named Nurse and Named Doctor for Safeguarding Children can provide advice related to assessing and managing risks in relation to children and child protection, including information-sharing with other agencies. See also the Trust’s Child Protection Manual and the Area Child Protection Committee procedures.

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 (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.

## Service users with complex personality disorders

In some cases it is not always in the best interests of the service users to offer an apology and may be counter active against existing care plans. These are generally self harm incidents were the incident was not as a direct result of care provided by the Trust. In such instances, the approach regarding Notifiable Safety Incidents is that following a clinical team discussion a clinical decision can be taken that an apology would not be in the best interests of the patient. This would need to be documented on the Duty of Candour section on Datix outlining why this decision had been taken. The documentation with full explanation would then allow the incident to be an exception. This documentation would show it had been considered and an exception had been implemented. Each incident would need to be considered on its own merits and there may be times when an apology is required and would be offered accordingly.

## Concerns about apologising

Staff should not be unduly concerned about apologising following a patient safety incident. An apology, an offer of treatment or other redress does not in itself amount to an admission of liability, negligence or a breach of statutory duty.

# Duties

## Executive Directors

The Trust Board has made a public statement supporting Being Open within the Trust and is ultimately responsible for ensuring that this policy is effectively implemented. Identified individuals and groups will provide assurance to the Trust Board as outlined below.

The Clinical Governance and Clinical Safety Committee has responsibility for scrutinising implementation of this policy on behalf of the Trust Board.

The chair of this Committee is the Non Executive Director with lead responsibility for the effective implementation of this policy.

The Director of Nursing and Quality has overall accountability and responsibility for the development, implementation and review of this policy.

The Director of Nursing and Quality and the Medical Director act as the central source of advice, support and mentoring to staff in implementing Being Open.

All Directors are responsible for implementing this policy within their area of responsibility although it is likely that this will usually be in liaison with clinical services.

## Patient Safety Support, Customer Services and Legal Teams

These teams will:

* Provide advice and training in relation to the management and review of patient safety events.
* Monitor the quality, effectiveness and timeliness of the review processes (PSST for serious incidents).
* Support and monitor openness in responding to complaints and incidents.
* Liaise with each other as necessary in relation to incidents which are also the subject of a complaint.
* PSST to provide monitoring reports to Commissioners, Quality Board, Clinical Governance and Clinical Safety Committee, Operational Management group and raise exceptions as they arise.

## Business Delivery Units

***The Director of Operations*** is responsible for the effective implementation of this policy and procedure in their areas of responsibility. This will include ensuring that:

* The policy is disseminated and implemented;
* Following a patient safety event affecting a service user the appropriate Being Open process is followed in accordance with this policy.

***Clinical leads, General managers and Matron, quality governance leads /Practice governance coaches and team managers*** are responsible for supporting the responsible director in the day-to-day implementation of this policy. This includes ensuring:

* Policy dissemination and implementation.
* That following a patient safety event the appropriate Being Open process is followed in accordance with this policy (see sections 4, 5, 6 and 7).

## Other Trust managers and specialist advisers

There will on occasions be complaints and patient safety events which affect service users which are not directly about clinical services. Being Open principles will still apply. Managers of the services concerned will liaise with clinical managers to agree the most appropriate way of applying *Being Open* in these situations.

## On call managers will:

* Support staff in implementing any immediate Being Open actions if an adverse event, particularly a patient safety event, occurs out-of-hours. (See sections 5, 6 and 7).
* Liaise with the responsible manager in relation to actions taken to ensure consistent implementation and follow up of the Being Open process.

## Managers, senior staff and clinicians responsible for immediate management of an adverse event

The most senior staff on duty at the time of the patient safety event will usually be responsible for:

* Managing the event and any initial Being Open actions (refer to sections 5, 6 and 7 for guidance) including initial decisions in relation to Being Open communications and meetings. This should be in consultation with a more senior or on call manager for serious incidents:
  + Clarify what has happened and agree factual information with the care team.
  + Identify who will make initial contact with service users and/or family/carers.
  + Take account of confidentiality issues ensure there is appropriate initial communication with service users and/or family/carers - including factual information, an apology, an explanation, and agreed follow up.
* Ensuring there is appropriate communication with external agencies.
* Ensuring the process and actions taken have been documented.
* Liaison with the senior managers responsible for the incident to agree and clarify follow up arrangements.

## Staff undertaking a Being Open communication or meeting

Nominated staff (usually including a lead person from the care team) will consider the following:

* Refer to sections 4, 5, 6 and 7 for guidance.
* Apologise (regret, say sorry) for what has happened.
* Explain factually what is known about what happened and why.
* Ask the service user and/or carers about any concerns they may have - give the opportunity to say why they thought it happened and/or went wrong.
* Provide opportunity for any other questions.
* Agree any future meetings as appropriate.
* Suggest any sources of support and counselling – if possible provide written information.
* If a review or investigation will be undertaken (eg complaint, safeguarding, patient safety incident) explain the process to the service user and/or carer and agree involvement and how feedback from the review process this will be given.
* Agree a contact person for the service user and/or family/carer who will be responsible for ongoing communication and follow up.
* Document the process as a separate record linked to the case notes with a complete, accurate record of the discussion(s) including date and time of each entry, what the service user and/or carer have been told and a summary of agreed action plans.

## Lead Investigators

The lead investigator appointed to undertake a review/investigation into a complaint or incident will:

* Liaise with the service line management team responsible for commissioning and supporting the investigation in relation to the status of the Being Open process
* If agreed with the responsible manager, meet with service users and/or relatives as part of the Being Open process in relation to:
  + Information about the adverse event.
  + Involvement in the review/investigation process.
  + Feedback of the findings and outcome of the review/investigation.
* If appropriate and agreed with the responsible manager include concerns raised by service users and/or carers in the scope of the review/investigation process.
* Include information about the Being Open process followed in the incident investigation report.

# Policy development, approval and review process

## Approval of the document

This policy has been approved by the Executive Management Team in accordance with the Trust’s policy for the development, approval and dissemination of policy and procedural documents. The Director of Nursing and Quality is responsible for the development and review of this policy.

## Consultation and communication with stakeholders

In developing this policy a range of stakeholders were identified and consulted.

|  |  |
| --- | --- |
| **Stakeholder** | **Level of involvement** |
| Executive Management Team | Approval |
| Directors | Consultation, dissemination, implementation, monitoring |
| Business Delivery Units (BDUs) | Consultation, dissemination, implementation, monitoring |
| Service user and carers | Consultation through development of national document |
| Trust Action Groups | Consultation |
| Specialist advisers | Consultation, support |
| Corporate teams – patient safety, complaints, claims and legal support | Development, consultation, dissemination, implementation, support, monitoring |
| Human Resources | Consultation |
| Local Authorities | Consultation |

## Equality Impact Assessment

The Trust is committed to providing services that meet the diverse needs of our service users, population and workforce. An equality impact assessment has been completed by the policy authors and approved by the EMT as part of the policy approval process in accordance with Trust policy (See Appendix A).

Although no specific equality issues were identified in relation to this policy, staff involved in Being Open communications with service users, carers and staff will need to be sensitive to any equality and diversity issues.

## Policy review process

This document will be reviewed in line with the Trust’s policy for the development, approval and dissemination of policy and procedural documents.

## Version control

The front cover indicates the version, date of issue and review date of this document.

# Dissemination and implementation arrangements (including training)

## Dissemination

This policy will be disseminated according to the Trust’s policy for the development, approval and dissemination of policy and procedural documents. It will be made available to staff through the Trust intranet system. Staff will be alerted to the policy through the Trust’s communications systems. Amendments to the policy will be disseminated through the same process.

## Implementation of the policy

The most up-to-date version of this policy will be available on the Trust intranet. Cross references to this process are included in the incident management policy and procedures.

## Training and support

Reference to the principles of Being Open and the Trust’s ‘just culture’ is included in Incident Reporting and Management policies and procedures and supporting documents on the [patient safety](http://nww.swyt.nhs.uk/incident-reporting/Pages/Training-and-guidance2.aspx) intranet pages.

The Medical Director and Director of Nursing and Quality and teams are available to provide support, advice and mentoring to staff undertaking a Being Open process.

The Customer Services, Legal and Patient Safety Support Teams can offer advice on the principles and implementation of Being Open.

Staff supervision/appraisal processes will assess competency, provide support and identify training needs in relation to Being Open.

# Process for monitoring compliance with this policy

The Executive Director of Nursing and Quality and Director of Operations is responsible for monitoring compliance with this policy.

The CQC, during inspections will assess whether the provider is delivering good quality of care. Two specific lines of enquiry under the Safe and Well led sections are relevant to Notifiable Safety Incidents.

* Are lessons learned and improvements made when things go wrong?
* How does the leadership and culture reflect the visions and values, encourage openness and transparency and promote good quality care?.

Relevant concerns about performance will be reported to the nominated responsible director and/or the Executive Management Team and an action plan developed. This will be achieved through:

|  |  |  |
| --- | --- | --- |
|  | **Standard** | **Monitoring process – evidence:** |
|  | This document is reviewed and updated in accordance with Trust policy and is up to date. | The document on the intranet is up-to-date |
|  | Relevant staff will be made aware of the policy | * Document is on the intranet * Reference in Headlines |
|  | Support and advice in implementing the policy is available | * Information for new staff will make reference to principles of Being Open and ‘just culture’ in line with the Trust values * Medical and Nursing Directors available to offer advice, mentoring and support re Being Open * Customer services and patient safety support teams able to give advice on process in relation to incidents and complaints * Systems Analysis training includes Being Open process * Systems Analysis and complaints management support documents provided to general managers and lead investigators |
|  | Levels of Being Open process are undertaken appropriate to the severity of event – full process offered in relation to all patient safety incidents where the degree of harm is moderate, severe or death (ie amber/red incidents) | Monitored through:   * Business Delivery Units management structure * Monitoring the Patient Safety Support and Customer Services Teams in relation to Being Open in incident, complaints and claims management respectively * Monitoring SI Additional Information and Local Investigation reports * Any issues identified will be acted on within individual cases and within themed analysis of recommendations * Quarterly reporting to commissioners * Feedback from external agencies (eg CCGs, Ombudsman) * Commissioning occasional internal audits of compliance with the process – either as a whole, or of specific aspects * Undertaking occasional service user/carer satisfaction surveys |

# Associated procedural documents and policies

This section includes the Trust’s supporting/linked procedural documents which should be used in conjunction with this document. A full list of current Trust policies, procedures and guidelines is available on the Trust intranet system. The list below identifies some of the key related documents. (This list is not exhaustive.)

**Trust documents:**

* Claims Management Policy and Procedure
* Customer Services Policy : supporting the management of complaints, concerns, comments and compliments
* Safeguarding Children Policy
* Incident Management policy and procedures
  + Incident reporting and management
  + Investigating and analysing incidents, complaints and claims to learn from experience policy
  + Supporting staff involved in traumatic or stressful adverse events (incorporating incidents, complaints, claims)
  + Learning from Healthcare Deaths

* Health and Safety policies, procedures and processes
* Human Resources and related policies and procedural documents including:
  + Whistle-blowing policy and procedures
  + Harassment and bullying policy
  + Stress (work related) policy
* Information Governance (and Caldicott Guardian) related policies and procedural documents
* Media and Communications – related policies and procedural documents

**Interagency documents and processes**

* Memorandum of Understanding: Investigating patient safety incidents involving unexpected death or serious untoward harm; a protocol for liaison between the NHS, the Association of Chief police officers and the NHS Health and Safety Executive
* Missing Service Users/patients Policy and Procedure *-* a joint protocol with West Yorkshire Police and the West Yorkshire Mental Health Trusts. Also South Yorkshire protocol
* *Safeguarding Children* – West Yorkshire Wide Local Authority Procedures (April 2007) - web-based. And South Yorkshire Local Authority Procedures
* Vulnerable Adults (prevention of abuse of) *-*  the Trust accepts the principles laid down within Barnsley, Calderdale, Kirklees and Wakefield Local Authorities multi-agency Adult Protection policies and procedures and is committed to working in partnership. Each policy can be found on the Trust intranet or via access to the appropriate local authority website
* NHS England and NHS Improvement
  + - NHS Patient Safety Strategy
    - Serious Incident Framework
    - Good practice principles for incident management (which is integrated into Trust policies).

# References, related recommendations and links

This policy is based on the policy and guidance provided by the National Patient Safety Agency, first issued in 2005, and updated in 2009. (now NHS Improvement).

Being Open is also consistent with recommendations by other national organisations and NHS commitments. Below are details of how other organisations encourage a culture of Being Open in the NHS.

**Regulators**

[The CQC’s regulation 20](https://www.cqc.org.uk/guidance-providers/all-services/regulation-20-duty-candour).

**Professional bodies and indemnity organisations**

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 professional duty is overseen by regulators of specific healthcare professions such as the General Medical Council (GMC), Nursing and Midwifery Council (NMC) and the General Dental Council (GDC).

The GMC’s Good Medical Practice guide contains the following statement on a clinician’s ‘duty of candour’:

*”If a patient under your care has suffered serious harm, through misadventure, or for any other reason, you should act immediately to put matters right, if that is possible. You should explain fully to the patient what has happened and the likely long and short-term effects. When appropriate, you should offer an apology. If the patient is under 16 and lacks the maturity to consent to treatment, you should explain the situation honestly to those with parental responsibility for the child.”*

**Reports**

Elements of the Being Open framework are also related to other government initiatives and recommendations from major inquiry reports, including:

* Recommendations in the Fifth Shipman Inquiry Report about appropriate documentation of patient deaths
* The NHSLA’s Striking the Balance initiative on providing support for healthcare professionals involved in a complaint, incident or claim
* The Francis Inquiry Report
* Sir David Dalton and Prof. Norman Williams, Building a culture of candour: a review of the threshold for the duty of candour and of the incentives for care organisations to be candid, <https://www.rcseng.ac.uk/policy/documents/CandourreviewFinal.pdf>

**Department of Health**.

* Health Service Circular (1999/198) The Public Disclosure Act 1998: Whistle blowing in the NHS. (1999)
* DOH Better NHS response for patients harmed by healthcare October 2005
* Help is at hand: a resource for people bereaved by suicide and other sudden, traumatic death : Department of Health – Publications

**Care Quality Commission and National Quality Board**

* Care Quality Commission (2016) Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England
* National Quality Board (2017) National Guidance on Learning from Deaths
* National Quality Board (July 2018) Learning from deaths - Guidance for NHS trusts on working with bereaved families and carers

**Health & Safety Executive.**

* Safety Cultures: Giving Staff a Clear Role - Contract Research Report 214/1999. (1999). HSE Books.
* The Keil Centre for the Health & Safety Executive. (2002). Evaluating the effectiveness of the Health and Safety Executive’s Health and Safety Climate Survey Tool. HSE Books.
* **Nieva, V.F. and Sorra, J. (**2003). [*Safety Culture Assessment: A Tool for Improving Patient Safety in Healthcare Organizations*](http://qshc.bmj.com/cgi/content/abstract/12/suppl_2/ii17). Quality & Safety in Health Care 2003; 12; 17-23.

# Appendix A - Equality Impact Assessment Tool

**Date of Assessment:** February 2020

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Equality Impact Assessment Questions:** | | **Evidence based Answers & Actions:** | |
| **1** | **Name of the document that you are Equality Impact Assessing** | | Being Open when things go wrong policy | |
| **2** | **Describe the overall aim of your document and context?**  **Who will benefit from this policy/procedure/strategy?** | | The overall aim of the policy is to describe the Trust’s approach to Being Open with service users and/or carers when things go wrong and provide a framework for staff to implement this process.  The document is to ensure that patients, their families and carers and staff all feel supported when patient safety events occur or things go wrong.  All communication (verbally or written) should be in line with the Accessible Information standards.  This assessment demonstrates that the policy will make an overall positive contribution to advancing equality in relation to Being Open and Notifiable Safety Incidents. We do not anticipate its implementation will have any negative impact on equality for people with protected characteristics. | |
| **3** | **Who is the overall lead for this assessment?** | | Director of Nursing, Quality and Professions | |
| **4** | **Who else was involved in conducting this assessment?** | | Assistant Director Patient Safety  Patient Safety Manager | |
| **5** | **Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?**  **What did you find out and how have you used this information?** | | Staff and managers were consulted during the development of this policy – which is based on a national NPSA policy which service users and carers were involved in the development.  N/A | |
| **6** | **What equality data have you used to inform this equality impact assessment?** | | To inform this equality impact assessment the following data has been considered:  [Census 2011](http://nww.swyt.nhs.uk/equality-impact-assessments/Pages/Resources.aspx) data for geographical areas  Equality dashboard  Staff Surveys information related to patient safety and safety culture as referenced in the [incident annual incident reports](http://nww.swyt.nhs.uk/incident-reporting/Pages/Incident-management-annual-report.aspx)  [Apparent suicide analysis report](http://nww.swyt.nhs.uk/incident-reporting/Pages/Incident-management-annual-report.aspx) – this includes data on apparent suicides and analysis of many of the protected characteristics. Annual data is reviewed and updated in reports.  Learning from Healthcare Deaths reports  SystmOne equality data  Patient Safety Strategy 2019-21 Equality Impact Assessment.  [Workforce equality data](http://nww.swyt.nhs.uk/Workforce/Pages/Staff-Groups-.aspx)  This data will be reviewed regularly. | |
| **7** | **What does this data say?** | | Through triangulating data from SystmOne and Equality Dashboard, it helps understand the communities we serve. It informs us that there are significant differences in the communities that this organisation provides services to and as such this Being Open policy needs to consider those differences and how information about harm can be relayed to all groups taking account of information requirements (which will be further enhanced through compliance with the Accessible Information Standard).  Culture is a huge determinant of the safety of the healthcare system. An environment where all staff feel supported and psychologically safe will be one that fosters inclusivity, with all staff confident to speak up when harm has occurred. Collectively, the initiatives to promote a patient safety culture as outlined in the Patient Safety Strategy and in this Being open policy will have a positive impact on all staff, particularly those from BME backgrounds, and indirectly a positive impact on all patients and their families.  Data relating to protected characteristics for individuals involved in incidents of harm is not available reliably on the Datix system. This is because information on any protected characteristics of the patients or staff involved in an incident (often multiple individuals) may not be immediately available to the reporter. It is recognised nationally (NHS Improvement) that making its collection mandatory could act as a barrier to reporting and lead to fewer patient safety incidents being reported (NHS Patient Safety Strategy Equality Impact Assessment July 2019). As such the new system will not mandate its collection. In line with national guidance, we consider it is more important to collect incomplete information about risks to patients than to potentially block reporting of that information by mandating the inclusion of information that reporters may not have. It is hoped that information collection for protected characteristics will be improved at the review/investigation stage of adverse events rather than incident reporting stage in the future through the work of NHS Improvement. The issue of lack of data acting as a barrier to incident reporting may then be irrelevant.  A new framework to review incidents will be introduced nationally that the Trust will adopt. This will replace the existing serious incident framework. This will bring more flexible approaches to investigation and review that may make it easier to address concerns specific to patients from minority cultural and language backgrounds, and those with disabilities. We will move to collect data for protected characteristics at review stage, as mentioned above. It will involve patients, families and carers more in the investigation of their incident should help them feel their concerns are being addressed. | |
| **8** | **Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:** | **Yes/No** | Evidence based Answers & Actions. Where Negative impact has been identified please explain what action you will take to remove or mitigate this impact. | |
| **8.1** | **Race** | **No** | We are aware that the Trust’s footprint varies greatly across the four regions.   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | % average | White | Asian | Black | Mixed | Chinese & Other | | Kirklees | 79.1 | 15.7 | 1.9 | 2.3 | 0.7 | | Barnsley | 97.9 | 0.7 | 0.5 | 0.7 | 0.2 | | Calderdale | 89.6 | 7 | 0.9 | 1.3 | 0.6 | | Wakefield | 95.4 | 2.6 | 0.77 | 0.9 | 0.29 |   Also see narrative under item 7.  Data for this characteristic is collected for apparent suicides which is analysed annually and presented in the apparent suicide incident report (link above). This is updated annually.  The policy recognises that some service users and families/carers may have different communication needs. In these cases plans for the meeting should fully consider these needs. Knowing how to enable or enhance communications with a service user or family members is essential to facilitating a process, focusing on the needs of individuals and their families and being personally thoughtful and respectful. All communication and information should be provided in line with [Accessible Information standards](http://nww.swyt.nhs.uk/Accessible-information-standard/Pages/Accessible-information-standard-.aspx). | |
| **8.2** | **Disability** | **No** | **Disability groups Day to day activities limited by disability**   |  |  |  |  | | --- | --- | --- | --- | | % average | Not at all | A little | A lot | | England % av. | 47.2 | 13.2 | 4.2 | | **Kirklees** | 45.5 | 12.5 | 13.7 | | **Barnsley** | 76.1 | 11.3 | 12.6 | | C**alderdale** | 56.5 | 12.2 | 13.8 | | **Wakefield** | 77.93 | 9.33 | 8.31 |   Also see narrative under item 7.  Data for this characteristic is collected for apparent suicides which is analysed annually and presented in the apparent suicide incident report.  In some cases such as where a patient has a complex personality disorder, it is not always in the best interests of the service users to offer an apology and may be counter active against existing care plans. These are generally self harm incidents were the incident was not as a direct result of care provided by the Trust. In such instances, the approach regarding Notifiable Safety Incidents is that following a clinical team discussion a clinical decision can be taken that an apology would not be in the best interests of the patient. This would need to be documented on the Duty of Candour section on Datix outlining why this decision had been taken. The documentation with full explanation would then allow the incident to be an exception. This documentation would show it had been considered and an exception had been implemented. Each incident would need to be considered on its own merits and there may be times when an apology is required and would be offered accordingly. | |
| **8.3** | **Gender** | **No** | |  |  |  | | --- | --- | --- | | **Gender** | **Male** | **Female** | | England % av. | 49.2 | 50.8 | | **Kirklees** | 49.4 | 50.6 | | **Barnsley** | 49.1 | 50.9 | | **Calderdale** | 48.9 | 51.1 | | **Wakefield** | 49 | 51 |   Also see narrative under item 7.  Data for this characteristic is collected for apparent suicides which is analysed annually and presented in the apparent suicide incident report.  Mortality data is analysed by gender.  The consideration of special cultural needs (such as for service users 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 on the most sensitive way to discuss the information. | |
| **8.4** | **Age** | **No** | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **AGE** | **0-15** | **16-29** | **30-44** | **45-64** | **65+** | | England % av. | 18.9 | 18.6 | 20.3 | 22.4 | 16.9 | | **Kirklees** | 15.8 | 18.5 | 20.3 | 22.2 | 15.8 | | **Calderdale** | 19.6 | 16.4 | 20.1 | 24.2 | 16.6 | | **Wakefield** | 18.4 | 17.2 | 19.6 | 24.2 | 17.6 | | **Barnsley**  (2011 data) |  | 16-24 | 25-44 | 45-59 | 60+ | | % average | 18.5 | 10.8 | 26 | 20.9 | 23.8 |   Also see narrative under item 7.  Mortality data is analysed by age.  Data for this characteristic is collected for apparent suicides which is analysed annually and presented in the apparent suicide incident report.  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 (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. | |
| **8.5** | **Sexual Orientation** | **No** | |  |  | | --- | --- | |  | **Living in a civil partnership** | | England % av. | 0.01 | | **Kirklees** | 0.01 | | **Barnsley**  (2011 data) | 0.2 | | **Calderdale**(2011 data) | 0.3 | | **Wakefield** | 0.01 |   Also see narrative under item 7.  Datix has recently been updated to include a question for reporters ‘Was the victim abused on assumptions of their gender identity or sexuality?’ This data will be reviewed by the LGBT staff network or relevant group. | |
| **8.6** | **Religion or Belief –** | **No** | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | % average | **Christian** | **Buddhist** | **Hindu** | **Jewish** | **Sikh** | **Muslim** | | **Kirklees** | 67.2 | 0.2 | 0.3 | 0.1 | 0.7 | 10.1 | | **Barnsley** | 59.4 | 0.5 | 1.5 | 0.5 | 0.8 | 5 | | **Calderdale** | 60.6 | 0.3 | 0.3 | 0.1 | 0.2 | 7.8 | | **Wakefield** | 66.4 | 0.16 | 0.25 | 0.04 | 0.12 | 2.0 |   Data for this characteristic is collected for apparent suicides which is analysed annually and presented in the apparent suicide incident report. |
| **8.7** | **Transgender** | **No** | As narrative under item 7.  Datix has recently been updated to include a question for reporters ‘Was the victim abused on assumptions of their gender identity or sexuality?’ This data will identify any incidents where patients are affected.  You must enter a value in this field | |
| **8.8** | **Maternity & Pregnancy** | **No** | Data for this characteristic is collected for apparent suicides which is analysed annually and presented in the apparent suicide incident report.  As narrative under item 7. | |
| **8.9** | **Marriage & Civil partnerships** | **No** | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | |  | **Married** | **Single** | **In a [registered] civil partnership** | **Divorced** | **Widowed** | **Separated** | | England % av. | 46.6 | 34.6 | 0.2 | 9.0 | 6.9 | 2.7 | | **Kirklees** | 48.4 | 32.4 | 0.2 | 9.3 | 6.8 | 2.8 | | **Barnsley** | 46.6 | 34.6 | 0.2 | 9 | 6.9 | 2.7 | | **Calderdale** | 46.7 | 32.1 | 0.3 | 10.5 | 7.3 | 3.0 | | **Wakefield** | 48.2 | 30.9 | 0.18 | 10.5 | 7.5 | 2.6 |   Data for this characteristic is collected for apparent suicides which is analysed annually and presented in the apparent suicide incident report.  As narrative under item 7. | |
| **8.10** | **Carers\***  **Our Trust requirement\*** | **No** | Where patients have died, families and carers will be the primary recipient on Being Open and Notifiable Safety Incidents communications. It is not anticipated there will be any negative impact on carers. Carers should be given information about how to raise concerns if they are not satisfied with the information they have been given. Leaflets to support bereaved families will be provided.  There are around 160,000 unpaid carers across SWYFT. This is split across SWYFT is as follows :-   * Calderdale: 21,369 * Kirklees: 43,665 * Barnsley 27,167 * Wakefield: 36,621   Data for this characteristic is collected for apparent suicides which is analysed annually and presented in the apparent suicide incident report.  As narrative under item 7. | |
| **9** | **What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-** | | Monitoring the compliance with this policy is through the Operational Management Group which reports to Executive Management Team. Duty of Candour is also part of the Patient Safety Strategy action plan. An audit on Duty of Candour compliance will be explored. | |
| **9a** | **Promotes equality of opportunity for people who share the above protected characteristics;** | | This policy promotes equality for opportunity for people who share the protected characteristics and does not promote bias in terms of opportunity. | |
| **9b** | **Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;** | | This policy does not condone any actions that would be perceived to be considered as discriminatory, harassing or bullying. The trust is committed to the values and vision as described within the introduction section of this policy. | |
| **9c** | **Promotes good relations between different equality groups;** | | This policy promotes best practice for our service users and carers and is underpinned by a value based ethos. | |
| **9d** | **Public Sector Equality Duty – “Due Regard”** | | N/A | |
| **10** | **Have you developed an Action Plan arising from this assessment?** | | **No** | |
| **11** | **Assessment/Action Plan approved by** | |  | |
|  | **(Director Lead)** | | **Sign: Mike Doyle Date: 17/2/2020**  **Title: Deputy Director of Nursing, Quality and Professions** | |
| **12** | ***Once approved, you must forward a copy of this Assessment/Action Plan to the Equality and Inclusion Team:***  [**inclusion@swyt.nhs.uk**](mailto:inclusion@swyt.nhs.uk)  **Please note that the EIA is a public document and will be published on the web.**  **Failing to complete an EIA could expose the Trust to future legal challenge.** | |  | |

# Appendix B - Checklist for the Review and Approval of Procedural Document

*To be completed and attached to any policy document when submitted to EMT for consideration and approval.*

|  | **Title of document being reviewed:** | **Yes/No/ Unsure** | **Comments** |
| --- | --- | --- | --- |
| **1.** | **Title** |  |  |
|  | Is the title clear and unambiguous? | YES |  |
|  | Is it clear whether the document is a guideline, policy, protocol or standard? | YES |  |
|  | Is it clear in the introduction whether this document replaces or supersedes a previous document? | YES |  |
| **2.** | **Rationale** |  |  |
|  | Are reasons for development of the document stated? | YES |  |
| **3.** | **Development Process** |  |  |
|  | Is the method described in brief? | YES |  |
|  | Are people involved in the development identified? | YES |  |
|  | Do you feel a reasonable attempt has been made to ensure relevant expertise has been used? | YES |  |
|  | Is there evidence of consultation with stakeholders and users? | EMT |  |
| **4.** | **Content** |  |  |
|  | Is the objective of the document clear? | YES |  |
|  | Is the target population clear and unambiguous? | YES |  |
|  | Are the intended outcomes described? | YES |  |
|  | Are the statements clear and unambiguous? | YES |  |
| **5.** | **Evidence Base** |  |  |
|  | Is the type of evidence to support the document identified explicitly? | YES |  |
|  | Are key references cited? | YES |  |
|  | Are the references cited in full? | YES |  |
|  | Are supporting documents referenced? | YES |  |
| **6.** | **Approval** |  |  |
|  | Does the document identify which committee/group will approve it? | YES |  |
|  | If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document? | N/A |  |
| **7.** | **Dissemination and Implementation** |  |  |
|  | Is there an outline/plan to identify how this will be done? | YES |  |
|  | Does the plan include the necessary training/support to ensure compliance? | YES |  |
| **8.** | **Document Control** |  |  |
|  | Does the document identify where it will be held? | YES |  |
|  | Have archiving arrangements for superseded documents been addressed? | YES |  |
| **9.** | **Process to Monitor Compliance and Effectiveness** |  |  |
|  | Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document? | YES |  |
|  | Is there a plan to review or audit compliance with the document? | YES |  |
| **10.** | **Review Date** |  |  |
|  | Is the review date identified? | YES |  |
|  | Is the frequency of review identified? If so is it acceptable? | YES |  |
| **11.** | **Overall Responsibility for the Document** |  |  |
|  | Is it clear who will be responsible implementation and review of the document? | YES |  |

# Appendix C - Version Control Sheet

**Being Open policy and guidance**

*This sheet should provide a history of previous versions of the policy and changes made*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Version** | **Date** | **Author** | **Status** | **Comment / changes** |
| 1 | Oct 2008 | Linda Hollingworth | Archived | New policy based on the NPSA Being Open policy - previously integrated into the Trust Risk Management Strategy and incident management policies and procedures |
| 2 | Dec 2010 | Linda Hollingworth | Archived | Amended policy to reflect NPSA Being Open framework 2009 |
| 3 | August 2012 | Julie Eskins | Archived | Updated policy to ensure Trustwide. |
| 4 | March  2014 | Wendy Beresford/Zoe Young | Archived | Updated following changes in NHS contract and commissioner reporting requirements |
| 5 | Dec  2014 | Julie Eskins | Archived | Updated following CQC regulation20: duty of candour |
| 6 | Jan 2017 | Sue Hastewell-Gibbs | Current | Updated following review. |
| 7 | April 2017 | Julie Eskins | Current | Following internal audit, it was recommended that the Trust should amend the policy to direct staff to further guidance on the need to consider mental capacity when delivering Duty of Candour and sharing information.  References or links have been made in section 2.4, 5.3 stage 5 and 7.3 |
| 8 | April 2017 | Elizabeth Broadbent | Current | Updated the EIA |
| 9 | May  2017 | Julie Eskins | Current | Amended formatting issues and added section 7.7 |
| 10 | Dec 2019-Mar 2020 | Helen Roberts | Current | Added references to   * NHS Patient Safety Strategy (2019) * Learning from healthcare deaths policy and associated national guidance. * Just Culture guide * Change of terminology:   ‘Root Cause’ to ‘Systems’ analysis  ‘investigation’ to ‘review’  Streamlined Being open stages   * Equality Impact Assessment * Front sheet * Added/updated role names in Trust * References updated |
| 11 | October 2021 | Helen Roberts | Current | Updated to reflect updated CQC regulation 20: duty of candour throughout and language change-update approved by EMT |
|  |  |  |  |  |
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# Appendix D - Identifying notifiable safety incidents





# Appendix E - Responding to notifiable safety incidents



1. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC, http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf [↑](#footnote-ref-1)
2. <https://cqc.org.uk/news/stories/updated-guidance-meeting-duty-candour> [↑](#footnote-ref-2)
3. <https://improvement.nhs.uk/resources/patient-safety-strategy/> [↑](#footnote-ref-3)
4. Sir David Dalton and Prof. Norman Williams, Building a culture of candour: a review of the threshold for the duty of candour and of the incentives for care organisations to be candid, <https://www.rcseng.ac.uk/policy/documents/CandourreviewFinal.pdf> [↑](#footnote-ref-4)
5. <https://improvement.nhs.uk/resources/just-culture-guide/> [↑](#footnote-ref-5)