Staff Support and Being Open Policy (Duty of Candour)

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What is in this policy?

University Hospitals Bristol and Weston NHS Foundation Trust (the Trust) has a duty of care to look after the psychological as well as the physical well-being of staff that have been exposed to a traumatic incident, complaint or claim. This policy sets out what support is available to staff in the short and longer-term, internally and externally, and details of how to access these.

The Trust also has a legal duty to communicate honestly and sympathetically with patients and their families when things go wrong. This is reflected in the Duty of Candour Regulations (Care Quality Commission 2015) for all NHS organisations.

Clearly, it is right to express regret when things go wrong, such as in adverse incidents, complaints or claims and staff should not worry that any expression of regret constitutes an admission of liability. In being open, the Trust can mitigate the trauma suffered by patients and families and potentially reduce complaints and claims.

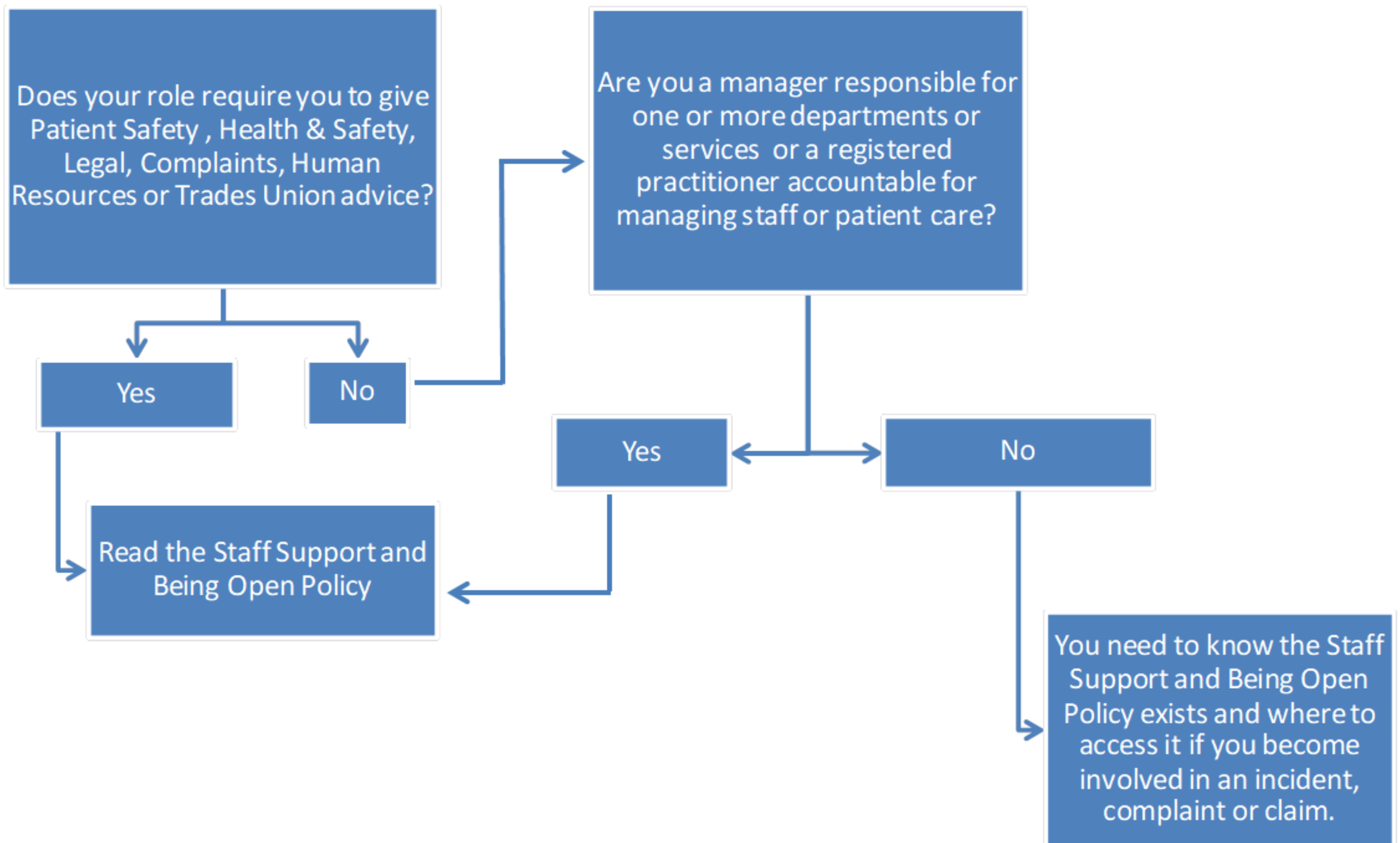
Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions (Job title only)**	**Type of Revision**	**Description of Revision**
July 2007	1	Medical Director	Major	Additional guidance for staff required
July 2008	2	Medical Director	Major	Review for comparison with new NHSLA risk management standards
January 2012	2.1	Medical Director	Minor	Interim update by author in response to Histopathology Inquiry 2010 pending full update for NHSLA Level3 March 2012.
June 2012	2.2	Head of Quality (Patient Safety)	Minor	Updated for NHSLA Level 3 and to reflect the Duty of Candour 2011.
March 2013	2.3	Head of Quality (Patient Safety)	Minor	New Appendix E added to reflect 2013/14 contractual requirements for Duty of Candour. Monitoring table updated.
December 2015	2.5	Patient Safety Manager (Education)	Major	Updated Policy to reflect Duty of Candour legislation.
July 2016	2.6	Patient Safety Manager (Education)	Minor	Aligning policy document with Standard Operating Procedure.
February 2018	2.7	Patient Safety Manager (Education)	Major	Review and revisions to bring the policy in line with CQC guidance in relation to Duty of Candour.
August 2018	2.8	Patient Safety Manager (Education)	Minor	Completed the Equal Opportunities Impact assessment and corrections put forward by the Policy Advisory Group
February 2019	2.9	Patient Safety Manager (Education)	Minor	Two minor corrections
March 2019	2.10	Patient Safety Manager (Education)	Minor	Clarification as to when the written notification should be sent or given to the patient or family.
February 2020	2.11	Patient Safety Manager (Education)	Minor	Addition of further clarifications and updates relating to duty of candour for patients with mental health issues, cognitive impairment and learning disabilities (sections 6.5 to 6.7).
January 2022	2.12	Patient Safety Manager	Minor	Policy updated in line with current process ownership clarified and flow chart added for ease.

Table of Contents

Do I need to read this Policy? 5
Policy Summary Flowchart 6
1. Introduction 8
2. Purpose 9
3. Scope 9
4. Definitions 9
4.1 Being Open 9
4.2 Duty of Candour 9
5. Duties, Roles and Responsibilities 10
5.1 Staff member directly involved in the incident 10
5.2 Line or Department Manager/Designated Senior Clinician 11
5.3 Divisional Directors 12
5.4 Executive Directors 12
5.5 Divisional Patient Safety Lead/Advisor 12
5.6 Patient Safety Managers 13
5.7 Occupational Health Service 13
6. Policy Statement and Provisions 13
6.1 How staff acknowledge, apologise and explain when things go wrong 13
6.2 Involving staff who made an error and staff support 14
6.3 Immediate Support; 14
6.4 Patient Considerations 15
6.5 The relevant person 15
6.6 Patients with mental health issues 16
6.7 Patients with cognitive impairment 16
6.8 Patients with learning disabilities 16
6.9 When a patient dies 16
6.10 Children 17
6.11 Independent Mental Capacity Advocate (IMCA) 17
6.12 Documentation of Duty of Candour and Being Open Discussions 17
6.13 Involving the Family in the Investigation Process 18

6.14 Completing the Process 18
6.15 On-going care 18
7. Standards and Key Performance Indicators 19
7.1 Applicable Standards 19
7.2 Training 19
8. References 19
9. Associated Documentation 20
Appendix A – Monitoring Table for this Policy 21
Appendix B – Dissemination, Implementation and Training Plan 22
Appendix D – Equality Impact Assessment (EIA) Screening Tool 22
Appendix E – Patient/Family Involvement 25
Appendix F – Workplace Wellbeing Services and Interventions 26
Appendix G – Relationship between Incident Reporting and Disciplinary Action 27
Appendix H –The 10 Principles of Being Open 29
Appendix I – NHS Resolution Saying Sorry Leaflet 32

Do I need to read this Policy?



Policy Summary Flowchart:

Duty of Candour applies to all notifiable safety incidents, where harm has been validated as Moderate, Major or Catastrophic and Unexpected Death incidents.

Incident occurs

Report incident on Datix and investigate as per Trust Policy for the Management of Incidents.

Harm is validated.

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Near Miss and No Harm incidents.

No requirement to inform or discuss with patient or relevant person

Low Harm incidents.

Inform patient or relevant person and offer appropriate apology

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Verbal notification.

As soon as reasonably practicable, following identification of the notifiable incident, the registered person must both verbally and in person:

- Provide the patient or relevant person a meaningful apology and an explanation of the facts known at the time of the event.
- Provide explanation that a Rapid Incident Review meeting will be held to review the events and, this will determine what type of review or investigation may take place.
- Ask if there are any immediate questions relevant to the incident that they would like explained to ensure they understand what has happened and the incident review process.

Document the discussion in the patient's record and complete the verbal notification DOC sections in Datix.

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Rapid Incident Review Meeting is held.

Members of the Divisional Patient Safety team, Trust Patient Safety team, a senior representative from the Division and a representative of the Executive team meet to discuss the incident, identify the learning and provide outcome of the review.

Please see: SOP for the Rapid Incident Review Meeting Process (insert link).

Update Datix with outcome of the Rapid Incident Review meeting.

↓ ↓

Following decision at RIRM further investigation is required eg: Patient Safety Incident Investigation (PSII), case notes review.

Following decision at RIRM no further investigation is required.

Written notification.

The patient/relevant person is to be sent or given written notification of the discussion outlined in the verbal notification section, including a sincere apology, along with the decision made at the Rapid Incident Review Meeting.

Use the RIRM DOC Trust template letter link here, the letter can also be accessed on the Duty of Candour section in Datix:

- If NO further investigation has been commissioned by the Executive team; complete the relevant sections of the letter. Ensure the patient/relevant person is provided with the letter. Offer the patient the opportunity for any further information as per Section 3: Supporting patient/relevant person and sharing the outcome of investigation.

- If further investigation has been commissioned by the Executive team; complete the letter. Ask the patient/relevant person whether they have any questions relevant to the incident that they would like to be included in the investigation.

Update the written notification section in DOC Datix.

Supporting the patient and sharing the outcome of investigation.

Offer the patient/the relevant person the opportunity to meet face to face to discuss the outcome of the investigation. Provide them with the key learning and recommendations that have been identified. Provide them with the opportunity to ask questions.

Update in Datix that a meeting has been offered to the patient/relevant person. Include whether they have accepted, the date scheduled and who met.

NB: if the patient or relevant person cannot be contacted, declines a discussion or does not consent to being contacted, document attempts made to contact patient in their records and in the Duty of Candour section in Datix.

No requirement to carry out verbal and written notifications of Duty of Candour.

1. Introduction

Effective communication with patients begins at the start of their care and should continue throughout their time with the healthcare organisation. This should be no different when an incident[1] occurs. Openness about what happened and discussing incidents honestly, promptly, fully and compassionately can help patients and families cope better with the after-effects.

The statutory duty of candour came into force in November 2014. This requires the Trust to give patients accurate, truthful and prompt information when mistakes are made and moderate harm has been caused as a result of failings in care.

Statutory duty of candour is also a requirement of the Care Quality Commission (CQC) regulatory framework. The principles sitting behind the new duty are wholly aligned to the wider drive around transparency and also entirely endorsed by the NHS Resolution in terms of health providers “being open” when errors are made and harm caused.

Saying sorry when things go wrong is vital for the patient, their family and carers. Patients, their families and carers should receive a meaningful apology; one that is a sincere expression of sorrow or regret for the harm that has occurred.

This policy is intended for use in conjunction with existing policies which deal with the management of incidents.

The same principle of ‘being open’ applies where there is a potential/actual complaint or claim relating to treatment or care. There are separate procedures to be followed for the investigation of complaints and claims.

The honest sharing of information with patients and families is important in reducing uncertainty, suspicion or anger. This principle was reinforced in the Francis Report on the failing at Mid-Staffordshire NHS Foundation Trust, published in February 2013, which explicitly recommended that it is a requirement for clinicians to be candid with patients about avoidable harm and for safety concerns to be reported openly and truthfully. It has long been recognised that patients are more likely to resort to formal complaints or pursuing litigation in the absence of appropriate explanation[2]. Openness with patients and families could reduce the number of formal complaints or potential litigation.

This policy ensures that the Trust complies with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

[1] Also known as a patient safety incident

[2] Vincent C, Young M, Phillips A, Why do people sue doctors? A study of patients and relatives taking legal action, The Lancet vol 343, 1609-13 (1994)

2. Purpose

The purpose of this guidance is three-fold:

(a) To ensure that staff understand their role in applying the statutory requirements in relation to duty of candour;

(b) To encourage the adoption of the principles of being open in disclosing information to patients and families following an incident;

(c) To recognise the need for staff support in following this guidance and involvement with an incident, complaint or legal enquiry including negligence actions and inquests[3].

3. Scope

This policy applies to all staff including permanent and temporary staff employed by the Trust. The policy also applies to students, bank and locum staff, contracted staff and volunteers. Every healthcare professional in the Trust must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress.

The being open principles and ethical duty of openness applies to incidents and any failure in care or treatment. The duty of candour applies to incidents whereby moderate, severe harm or death has occurred.

4. Definitions

4.1 Being Open

Acknowledging, apologising and explaining when things go wrong and, in the case of incidents, recording this in the patient's clinical records, and if relevant the investigation report. Conducting a thorough investigation and reassuring families that lessons learned will help prevent the incident from happening again.

4.2 Duty of Candour

Candour is defined in the Francis Report:

"The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not information has been requested and whether or not a complaint or report about that provision has been made."

Unlike the existing professional and ethical duty which applies to all circumstances where a patient is harmed when something goes wrong, the statutory duty of candour only applies to incidents where a patient suffered (or could have suffered) unintended harm resulting in moderate or severe harm, death or prolonged psychological harm.

[3] Chief Medical Officer. Making Amends – Clinical Negligence Reforms. DoH (2003)

The person best suited to meet the requirements of the duty of candour and be the key contact for the patient or relevant person (*see section 6.5 for explanation of the relevant person)* in this respect should be identified by the relevant division guided by the complexity of the incident. Key contacts need to have sufficient experience in having difficult conversations with the families and have the appropriate clinical knowledge to respond to any initial questions from the patient or relevant person.

5. Duties, Roles and Responsibilities

5.1 Staff member directly involved in the incident

When a staff member is made aware that something untoward has happened, they should treat the concerns seriously, immediately consider whether this is an incident and take appropriate action. This includes but is not limited to:

(a) Reporting the incident as per the Policy for the Management of Incidents and the Trust's Serious Incident Policy and guidelines;

(b) Determining with their line manager or senior clinician how the patient and/or relevant person is to be informed. This should include an explanation of what happened and the likely harmful impact;

(c) Apologising to patients, or the relevant person, harmed as a result of healthcare treatment as early as possible. Staff involved in patient care or treatment which results in an incident, for whatever reason, should display empathy with the patient or the patient's relevant person and express sorrow or regret at the outcome (such expressions of regret would not normally constitute an admission of liability, either in part or in full, solely on the grounds of such an expression). The importance of openness is also emphasised in the NHS Resolution Saying Sorry Guidance4 (appendix G).

It is not, however, a requirement for near misses or 'no harm' incidents to be discussed with patients and/or their carers due to potential:

(i) Added stress to patients;

(ii) Loss of confidence in the standard of care;

(iii) Negative effects on staff confidence and morale;

(iv) Decreased public confidence in the NHS.

It is important that the duty of candour related discussions with the patient and/or relevant person are documented in the patient's notes.

Low harm incidents: inform patient or relevant person verbally and offer an appropriate apology

[4] NHS Resolution Saying Sorry Guidance

5.2 Line or Department Manager/Designated Senior Clinician

When a manager is made aware that something untoward has happened, they should treat the concerns seriously, immediately consider whether this is an incident and take appropriate action. This can include, but is not limited to:

(a) Ensuring the incident has been appropriately reported and that patient or relevant person has been informed;

(b) If the level of harm is determined to be moderate, severe harm or death, then the patient or the relevant person must be informed. This must be followed by written notification (detailed in paragraph g) unless the patient declines to receive this document. The notification must be sent or given to the patient or family within 5 workings days after the initial discussion took place.

(c) Where the degree of harm is not yet clear but may fall into the moderate harm or above categories in the future, the patient or relevant person must be informed of the incident;

(d) Apologise to patients harmed as a result of healthcare treatment as soon as reasonably practicable following identification of the notifiable safety incident, if the staff member involved is unable to do so,(such expressions of regret would not normally constitute an admission of liability, either in part or in full, solely on the grounds of such an expression). The importance of openness is also emphasised in the NHS Resolution standards;

(e) Ensure that a step-by-step account of all relevant facts known about the incident at the time is given, in person, by one or more appropriate representatives of the provider. This should include as much or as little information as the patient or relevant person wants to hear, be jargon-free and explain any complicated terms;

(f) Ensure that written notification is given or sent to the patient or relevant person following the notification that was given in person (see b), even though enquiries may not yet be complete. The written notification must contain the named registered person contact details to ensure the patient or relative person can continue to receive support and appropriate updates through the investigation process. The written notification must contain all the information that was provided in person, including an apology, as well as the results of any enquiries that have been made since the notification in person;

(g) Confirm with the patient or relevant person if they would like feedback on the outcome of any incident investigation or further enquires;

(h) If the patient or relevant person cannot be contacted or declines to speak to the Trust member of staff then this must be fully documented in the patient’s notes;

(i) Follow sections 6.2 – 6.7 for management of the feedback to the patient;

(j) Follow section 6.1 to ensure all relevant staff members receive suitable support depending on the particular circumstances.

(k) **On-Going Support**

(i) Refer or provide information about Occupational Health Services.

(ii) Offer face to face debrief to individual staff member or team.

(iii) Consider reassignment as a temporary measure.

(iv) Consider special leave or relevant Human Resources Policies (Capability, Special Leave, Link between Incident & Disciplinary, Work-Related Stress Policy).

(v) Further support may be required from the Patient Safety Team (x23710).

(vi) Advice and support may be sought from the Occupational Health Department including counselling services (ext 23400).

(vii) Consider referral to the relevant professional or union representative organisation.

(viii) Where necessary refer to relevant executive director for referral to the professional regulatory authority.

(ix) Assistance with the preparation of witness statements and oral evidence. Follow links to claims and incident policies in section 8.

Appendix E sets out the wellbeing services and interventions provided by the Trust.

5.3 Divisional Directors

(a) Divisional Directors are responsible for ensuring that the systems for ensuring Duty of Candour compliance and support for patients/family and staff are resourced and implemented within their division and that all staff are aware of their responsibilities

5.4 Executive Directors

(a) Executive Directors are responsible for ensuring that the Trust complies with its statutory and regulatory obligations in respect of Duty of Candour. They are also responsible for ensuring that the Trust has in place appropriate levels of support for patients/family and members of staff involved in incidents which have resulted in physiological or psychological harm.

5.5 Divisional Patient Safety Lead/Advisor

(a) Identify particular staff support requirements as per section 6.2.

(b) Ensure patient/relevant person feedback has been provided (see sections 6.3 – 6.7).

(c) Ensure the Datix incident management system is updated with full details in respect of duty of candour including feedback provided to patient/relevant person and any written notifications regarding the incident (section 5.2, see paragraph f) are attached.

5.6 Patient Safety Managers

(a) Ensure incident is investigated appropriately and reported to the relevant management group.

(b) Ensure staff members involved have received feedback on the outcome of the investigation of the incident, complaint or claim.

5.7 Occupational Health Service

(a) The Avon Occupational Health Service is responsible for providing a confidential support service which meets the physiological and psychological needs of staff affected by their involvement in serious incidents (see Serious Incident Policy).

6. Policy Statement and Provisions

The Trust is committed to the principles of openness and this policy details the meaning of these principles in practice. Clearly, it is right to express regret when things go wrong, such as in adverse incidents, complaints or claims and staff should not worry that any expression of regret constitutes an admission of liability.

This policy seeks to reflect the ethical and legal obligations relating to candour in relation to patients, visitors and staff members[5]. It is also recognised that a culture of openness is a prerequisite conditionfor improving patient safety and the quality of the healthcare provided by this Trust[6].

6.1 How staff acknowledge, apologise and explain when things go wrong

Moderate and severe harm incidents and catastrophic incidents where death was avoidable

As soon as reasonably practicable, following identification of the incident, verbally and in person, the clinician responsible for the patient's care informs the patient or relevant person of the incident including all facts known at the time and provides an appropriate apology. This should include as much or as little information as the patient or relevant person wants to hear, be jargon-free and explain any complicated terms.

Provide the patient or relevant person with written confirmation of the discussion. If a formal incident investigation is to be conducted the patient or relevant person must be asked if they have any questions they would specifically like answered as part of the investigation. The patient or relevant person must be given the opportunity to receive the outcome of the investigation. The patient or relevant person should be approached first and asked how they would like to be involved in the investigation. They should also be given the patient information leaflet 'Guide for adult patients and their families about investigations of unexpected events and incidents'.

[5] Shipman Inquiry, 5th Report. Safeguarding patients: Learning from the Past – Proposals for the Future. Command Paper Cm 6394 (2004)

[6] Manchester Patient Safety Framework – National Patient Safety Agency (2006)

All discussions and outcomes must be noted in the patient record. Initial discussion needs to be followed up in writing unless the patient declines (NB: if the patient or relevant person cannot be contacted or decline a discussion this should also be recorded in the patient record). This should be a personal letter which includes the key points from the initial face to face discussion i.e. apology, facts known at the time (if any), level of investigation. Examples can be found on the duty of candour page on Connect. A copy of the letter sent to the patient must be uploaded into the Datix incident management reporting system.

Formal incident investigations e.g. Patient Safety Incident Investigations (PSIIs)

Include the patient's or relevant person's questions in the scope of the investigation and document being open and duty of candour requirements in the PSII report using the Trust PSII template.

The patient or relevant person must be offered the opportunity to review the final draft version of the report for factual accuracy and for points of initial clarification. Before the draft report is shared with the patient or relevant person, the commissioning executive director must sign off the draft for release. Please refer to Trust policies Incident Management Policy and Serious Incident Policy.

Within 10 working days of completion and sign off of formal investigation report (in accordance with Trust Policy for the Management of Incidents) the patient or relevant person should be provided with a copy of the incident investigation report. Unless the patient or relevant person decline, this should be done at a face to face meeting to explain the process of the investigation and provide the opportunity to answer any questions which may arise.

6.2 Involving staff who made an error and staff support

Some patient safety incidents will result from errors made by healthcare staff while caring for the patient. The member(s) of staff involved may or may not wish to participate in the discussion with the patient or relevant person. Each case should be considered, balancing the needs of the patient or relevant person with those of the healthcare professional concerned.

Where a healthcare professional who has made an error wishes to attend the discussion to apologise personally, they should be supported by their colleagues throughout the meeting. In cases where the patient or relevant person prefers the healthcare professional not to be present and the healthcare professional wishes to offer a personal apology, an offer of a personal written apology from the healthcare professional could be made to the patient or relevant person during the first discussion.

Healthcare professionals involved in the patient's clinical care which involved a patient safety incident may require emotional or practical support and advice.

6.3 Immediate Support;

Clinicians who have been involved directly in the incident and those with the responsibility for discussions must be offered access to assistance, support and any information they need to fulfil this role, e.g. details of what happened and when. These must be the objective facts as known at

that time, not subjective opinions. Further support may be required from peers or managers for staff to discuss the incident.

Staff should consider self-referral to the relevant professional or union representative organisation for any further support.

6.4 Patient Considerations[7]

Overall Principles

Repeated opportunities for the patient or relevant person to obtain information about the patient safety incident should be offered. Information should be given to patients initially verbally and face-to-face and provide confirmation of discussion(s) in writing unless declined.

On-going care plans will be developed in consultation with the patient and they should be assured that the plans will be followed through.

Patients and relevant persons should be provided assurance that the patient will continue to be treated according to their clinical needs and that the prospect of, or an actual dispute between, the patient and/or their carers' and the healthcare team will not affect their access to treatment.

All reasonable support should be provided to the patient or relevant person involved in the incident.

6.5 The relevant person

Is either the person who was harmed (the patient) or someone acting lawfully on their behalf. Someone may act on the behalf of the person who was harmed if:

a) the person has died
b) is under 16 and not competent to make decisions about their care or the consequences of the incident
c) is over 16 and lacking mental capacity.

This is in accordance with the Mental Capacity Act 2005.

If the relevant person consents, we would expect to see that you have involved family members and carers in any discussions. It is about taking reasonable steps to make sure you communicate in a way that is as accessible and supportive as possible.

CQC Regulation 20 Duty of Candour: Guidance for Providers

[7] See Guidance for Supporting and Working with Patients/Families After Unexpected Death Of An Adult or Serious Incident Involving An Adult (University Hospital Standard Operating Procedure). For Children contact the Children's Bereavement Service.

6.6 Patients with mental health issues

Being open for patients with mental health issues should follow normal procedures unless the patient also has cognitive impairment (see below). The only circumstances in which it is appropriate to withhold patient safety incident information from a mentally ill patient is when advised to do so by a consultant psychiatrist who feels it would cause adverse psychological harm to the patient. However, such circumstances are rare and advice and assistance should be obtained from the Trust Patient Safety Team, Psychiatric Liaison Team, Safeguarding Team and Legal Team. Apart from in exceptional circumstances, it is never appropriate to discuss patient safety incident information with a carer or relative without the express permission of the patient. To do so is a breach of patient confidentiality and an infringement of the patient’s human rights.

6.7 Patients with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them and should be treated in accordance with the Mental Capacity Act. A patient with a cognitive impairment should be supported and, wherever possible, involved directly in communications about what has happened. The patient may have previously authorised a person to act on their behalf via a valid lasting power of attorney for health and welfare. If this is the case, the being open discussion can be held with the holder of the power of attorney. In the absence of an attorney, friend, relative or carer advocate an IMCA (Independent Mental Capacity Advocate) should be instructed to act on the individual's behalf. Advice and assistance can be obtained from the Trust Patient Safety Team, Safeguarding Team and Legal Team.

6.8 Patients with learning disabilities

Early consideration of support for patients with learning disabilities should be given during the being open process. If a patient is assessed as lacking capacity the Mental Capacity Act should be followed to provide information to the patient and support their decision making regarding further information following an incident investigation. Reasonable adjustments such as provision of an advocate or alternative communication methods should made in order to meet the needs of individuals and to comply with duty of candour. In the absence of a friend, relative or carer advocate an IMCA (Independent Mental Capacity Advocate) should be instructed to act on the individual's behalf. Advice and assistance can be obtained from the Trust Patient Safety Team, Safeguarding Team and Legal Team.

6.9 When a patient dies

The emotional state of bereaved relatives or carers should always be considered and involved in deciding when it is appropriate to discuss what has happened. The patient’s family and/or carer will need information on the processes that will be followed to identify the cause(s) of death. They will also need emotional support. In the case of childcare, this is provided by the Children Bereavement Team and for adult patients, by the relevant clinician. Establishing open channels of communication may also allow the family and/or carers to indicate if they need bereavement counselling or assistance at any stage.

Ensure the notification of relevant community health care staff including the patient’s GP takes place.

Usually, the discussion and any investigation occur before the Coroner's Inquest. In certain circumstances, the Trust may consider it appropriate to wait for the Coroner's Inquest before the discussion with the patient's family and/or carers. Advice can be sought from the Legal Department on ext 23612. The Coroner's report on post-mortem findings is a key source of information that will help to complete the picture of events leading up to the patient's death. A copy is provided to the patient's GP. Expressions of sympathy and regret, where appropriate, should be offered as soon as possible after the patient's death. An information leaflet outlining the coroner's process should be offered. Referral of the family to the Coroner's office should facilitate further details of the likely timeframe of when the family and/or carers will be provided with more information. Please refer to the Trust Serious Incident Policy.

6.10 Children

A young person acquires the full rights to make decisions about their own treatment and their right to confidentiality overrides their parents or guardians at the legal maturity age of 16. Therefore it is possible to discuss a patient safety incident with a teenage patient alone, but, it is usually preferable to involve parents/carers with the child's permission.

6.11 Independent Mental Capacity Advocate (IMCA)

If the patient is deceased, the Trust's responsibility with regards to being open and the duty of candour applies to a person lawfully acting on behalf of the patient. Careful consideration is required in these circumstances with due regard to protecting patient confidentiality and identifying those lawfully acting on behalf of the patient. If in doubt advice should be sought from the Trust's legal team.

In the situation where the patient is deceased and an independent mental capacity advocate (IMCA) has been acting on behalf of the patient when they were alive, the IMCA has no lawful role after the patient is deceased and therefore it would be a breach of patient confidentiality to further communicate with the IMCA with regard to any investigation or its outcome.

There may however be specific occasions when sharing a degree of information with the IMCA should be considered. For example, if the IMCA has raised specific concerns about the Trust on behalf of the patient in their lifetime, then it may be considered appropriate to provide assurance that the issue has been fully considered and appropriate action taken. Information sharing decisions, in these circumstances, should be considered on a case by case basis. Advice should be sought from the Trust secretary.

6.12 Documentation of Duty of Candour and Being Open Discussions

Documentation should include the following:

(a) The time, place, date, name and relationships of all attendees.

(b) The agreed plan for providing further information to the patient or relevant person.

(c) Offers of assistance and the response from the patient or relevant person.

(d) Questions raised by the patient or relevant person, and the answers given.

(e) Plans for follow-up and feedback as discussed.

(f) Progress notes relating to the clinical situation and an accurate summary of all the points explained to the patient/carers.

(g) Copies of letters sent to patients, carers and the GP for patient safety incidents not occurring within primary care.

6.13 Involving the Family in the Investigation Process

Please refer to the Trust Serious Incident Policy and appendix E of this policy for details of how patients and family members (with the patient's consent where appropriate) can be involved in the incident investigation process.

6.14 Completing the Process

As soon as is reasonably practicable after signing the incident investigation off in accordance with the Incident Management Policy and accordance with the patient or relevant person's wishes, a copy of the incident investigation report should be provided if the patient or relevant person has taken up this offer. Feedback should ideally occur in a face to face meeting and a copy of the report provided but may use another form if more acceptable to the patient. The communication should include:

(a) A repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the patient safety incident.

(b) The chronology of clinical and other relevant facts.

(c) Details of the patient or relevant person's concerns and complaints.

(d) A summary of the factors that contributed to the incident.

(e) Information on what has been and will be done to avoid recurrence of the incident and how these improvements will be monitored.

(f) A complete discussion of the findings of the investigation and analysis.

In some limited cases, information may need to be withheld or restricted. For example:

(g) Where communicating information is likely to adversely affect the health of the patient.

(h) Where investigations are pending coronial processes unless the Coroner gives permission. Consult the Legal Services team for advice.

(i) Where specific legal requirements preclude disclosure for specific purposes. In these cases, the patient will be informed of the reasons for the restrictions. Consult the Legal Services team for advice.

6.15 On-going care:

Patients/relevant person's should be reassured that they will continue to be treated according to their clinical needs even in circumstances where there is a dispute between them and the healthcare team.

They should also be informed that they have the right to continue their treatment elsewhere if they have lost confidence in the healthcare team involved in the patient safety incident.

7. Standards and Key Performance Indicators

7.1 Applicable Standards

(a) Provision of apology.

(b) Notifying patient and/or family of the incident.

(c) Documentation of the duty of candour discussions are evidenced in the patient's notes.

(d) If relevant, family to review investigation outcome.

(e) Staff affected by the incident are offered the appropriate level of support.

7.2 Training

Training on all aspects of incident investigation can be found on the Patient Safety Training pages of connect.

Resources are available on duty of candour pages of the Trust connect site.

Duty of candour included in Patient Safety Update, Trust Induction, Doctors Induction and Root Cause Analysis Training.

8. References

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Chief Medical Officer. Making Amends – Clinical Negligence Reforms. DoH (2003)

National Health Service Litigation Authority (NHSLA) Saying Sorry Guidance

National Patient Safety Agency. Being Open Communicating Patient Safety Incidents with Patients and their Carers. London: (2005)

Walker S. Apologies and Explanations, Chief Executive letter to NHS Trust Chief Executives, August 2007. http://www.nhsla.com

National Health Service Litigation Authority (2008) Risk Management Standards for Acute Trusts

Vincent C, Young M, Phillips A, Why do people sue doctors? A study of patients and relatives taking legal action, The Lancet vol 343, 1609-13 (1994)

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Shipman Inquiry, 5th Report. Safeguarding patients: Learning from the Past – Proposals for the Future. Command Paper Cm 6394 (2004)

Manchester Patient Safety Framework – National Patient Safety Agency (2006) www.npsa.org.uk

9. Associated Documentation

Incident Management Policy

Serious Incident Policy

Complaints and Concerns Policy

Dignity at Work Policy

Work-Related Stress Policy

Special Leave

Safeguarding Adults Policy

Advice on preparing statements and recollections of events on the Patient Safety intranet

Appendix A – Monitoring Table for this Policy

The following table sets out the monitoring provisions associated with this Policy.

Objective	Evidence	Method	Frequency	Responsible	Committee
Provision of apology.	Completed PSII report.	Duty of Candour audit	Six Monthly	Trust Headquarters Patient Safety Team	Patient Safety Group
Providing written Notification within 5 working days from the date of the initial discussion for the patient or relevant person.	Completed PSII report.	Duty of Candour audit.	Six Monthly	Trust Headquarters Patient Safety Team	Patient Safety Group
Documentation of Duty of Candour discussions are evidenced in the patient's notes and uploaded onto Datix.	Audit will be undertaken to measure compliance with Duty of Candour legislation	Duty of Candour Audit	Six monthly	Trust Headquarters Patient Safety Team	Patient Safety Group
Attempts made to contact the patient or relevant person	Datix and /or patient's notes	Duty of Candour audit	Six Monthly	Trust Headquarters Patient Safety Team	Patient Safety Group
patient or relevant person have received a copy of the final report	Datix	Duty of Candour Audit	Six Monthly	Trust Headquarters Patient Safety Team	Patient Safety Group

Appendix B – Dissemination, Implementation and Training Plan

The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	Head of Quality (Patient Safety)
Is this document: A – replacing an expired policy, B – replacing an alternative policy, C – a new policy:	A
Alternative documentation this policy will replace (if applicable):	[DITP - Existing documents to be replaced by]
This document is to be disseminated to:	Trust-wide
Method of dissemination:	Document Management System, Newsbeat and Patient Safety Group and Clinical Quality Committee for dissemination to divisions
Is Training required:	No
The Training Lead is:	[DITP - Training Lead Title]

Additional Comments
[DITP - Additional Comments]

Appendix D – Equality Impact Assessment (EIA) Screening Tool

Query	Response
What is the main purpose of the document?	To ensure statutory and regulatory compliance in respect of Duty of Candour and ensure that patient
Who is the target audience of the document (which staff groups)? Who is it likely to impact on? (Please tick all that apply.)	Add ☑ or ☒ All Trust Staff Staff ☑ Patients ☑ Visitors Carers ☑ Others

Could the document have a significant **negative** impact on equality in relation to each of these characteristics?	YES	NO	Please explain why, and what evidence supports this assessment.
Age (including younger and older people)		No	

Disability (including physical and sensory impairments, learning disabilities, mental health)		No	
Gender reassignment		No	
Pregnancy and maternity		No	
Race (includes ethnicity as well as gypsy travellers)		No	
Religion and belief (includes non-belief)		No	
Sex (male and female)		No	
Sexual Orientation (lesbian, gay, bisexual, other)		No	
Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)		No	
Human Rights (particularly rights to privacy, dignity, liberty and non-degrading treatment)		No	

Will the document create any problems or barriers to any community or group? NO

Will any group be excluded because of this document? NO

Will the document result in discrimination against any group? NO

If the answer to any of these questions is YES, you must complete a full Equality Impact Assessment.

Could the document have a significant **positive** impact on inclusion by reducing inequalities?	YES	NO	If yes, please explain why, and what evidence supports this assessment.
Will it promote equal opportunities for people from all groups?		No	
Will it help to get rid of discrimination?		No	
Will it help to get rid of harassment?		No	
Will it promote good relations between people from all groups?	Yes		The policy encourages an open and honest relationship with patients/family involved in serious incidents
Will it promote and protect human rights?		No	

On the basis of the information/evidence so far, do you believe that the document will have a positive or negative impact on equality? (Please rate by circling the level of impact, below.)

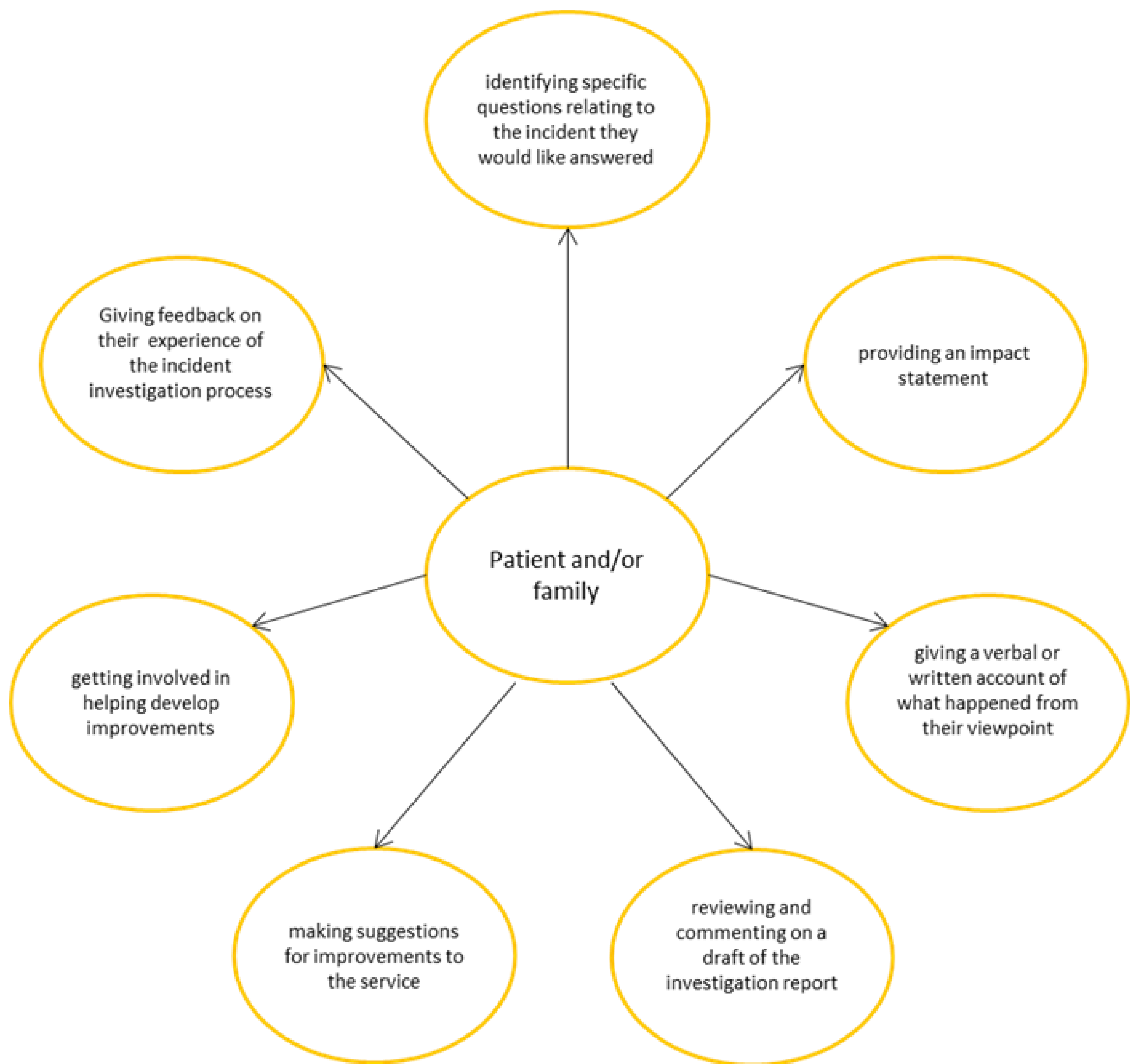
Positive impact				Negative Impact		
Significant	Some	Very Little	NONE	Very Little	Some	Significant

Is a full equality impact assessment required? NO

Date assessment completed: .1st August 2018...

The person completing the assessment: ....[redacted]..

Appendix E – Patient/Family Involvement



Appendix F - Workplace Wellbeing Services and Interventions

Workplace Wellbeing Services and Interventions

University Hospitals Bristol
NHS Foundation Trust

Psychological Wellbeing

Preventative & Self-management

- Psychological & Emotional page on HRweb
- Staff Side (Union) Support
- Money Advice HRWeb Page
- Buddhism and Meditation (weekly)
- Voice of Hope Gospel Choir
- Schwartz Rounds
- Step into Health Module: Stress Management
- Resilience Building Programme (Jan 19)
- Management Development Workshop

Targeted Support

- Staff Counselling (Occupational Health)
- Managers Guidance on Suicidal Intent
- Coping after a Traumatic Event (Guide)
- Work Related Stress Tools/Audits
- Psychological Health Services; applied psychology, training, debriefs, etc.
- Mental Health First Aid training
- Self-Harm Managers Guidance (Sept18)

Physical Wellbeing

Preventative & Self-management

- Physical Activity HRWeb Page
- Manual Handling – Sit/Stand Desk
- Yoga (all levels - weekly)
- Buzzer Challenge
- Step into Health Module: Physical Activity and Health
- Physical Activity Challenge
- Cycle to Work Scheme (May & August)

Targeted Support

- Physio Direct – MSK issues
- Occupational Health Surveillance
- Occupational Health Referrals (manager)
- Occupational Health Contamination Service
- getUbetter Back Pain App

Healthy Lifestyles

Preventative & Self-management

- Workplace Wellbeing Section - HRWeb
- Making Every Contact Count (MECC)
- Smoking Cessation Support - HRWeb
- Travel Health Advice & Immunisations (Occupational Health)
- Staff E-Social Club (Bulletin Board)
- Healthy Eating Guidance HRWeb
- Cancer Care Workshop
- Alcohol Support & Guidance - HRWeb
- Step into Health Module: Nutrition and Weight Management
- Menopause Workshop

Targeted Support

- Pregnancy Workshops (monthly)
- Flu campaign (October to February)
- NHS over 40's Health Check

Visit our HRWeb section: Http://goto/Wellbeing

Additional Resources

- Wellbeing Advocate Network
- Domestic Abuse Guidance
- Staff Forums – HR Webb
- Staff Discount List
- Green Initiatives – HR Webb
- Arts & Culture Programme
- Monthly Wellbeing Newsletter
- Happy App (desktop icon)

Supporting Policies/Governance

- Smoke Free Policy
- Maternity Leave Policy
- Work Related Stress Policy
- Time to Change Action Plan
- Supporting Attendance Policy
- Violence & Aggression (conflict)
- Workplace Wellbeing Steering Group (see Workspace)

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Please contact the Workplace Wellbeing team if you require any further information or a copy of this document: x 22113 Wellbeing@UHBristol.nhs.uk

Appendix G – Relationship between Incident Reporting and Disciplinary Action

Our assurance to employees:

(a) A culture of “fair blame” will operate.

(b) The Trust believes that the emphasis must be on taking corrective action, learning from the experience and improving practice accordingly.

(c) An open and thorough investigation may reveal that it is the system or process at fault which resulted in an individual(s) making a mistake.

(d) It is assumed that in discharging their responsibilities staff act in good faith and within their sphere of professional practice and competence.

(e) However, the actions of an individual, in the event of an incident, maybe tested against the NHS England Just Culture Guide which is a standardised assessment tool.

(f) All new members of staff will be informed of this policy at induction.

Incident Reporting

(g) The aim of Datix incident management reporting is not to apportion blame. The purpose of incident reporting is to ensure mistakes or potential mistakes [near misses] are highlighted and reported to the Trust so that they can be avoided in future or the risk of their occurrence minimised. Thus, the system is an essential part of improving patient care and safeguarding the patient from harm. The Trust has adopted a proactive approach to risk management by identifying risks, assessing risks and reducing or where possible eliminating risks to patients.

(h) Staff are encouraged to report any incidents or near misses and consider them as an opportunity to learn from errors and ultimately improve patient care. A report by a staff member may either involve them as an individual or a colleague. The individual needs to be assured that the Trust does not take a punitive approach, but needs to find out what happened to prevent a reoccurrence. An individual’s actions, therefore, may be assessed using the standardised Just Culture Guide assessment tool.

(i) Where an incident is considered to be serious, managers will explicitly ensure that, during the investigation into an incident or near miss, staff members involved will be given specific personal support.

(j) All incidents are investigated using a ‘systems’ approach that looks at a number of contributory factors e.g. system faults, catalyst events, as well as human error.

Relationship between Disciplinary Action and Reporting Incidents

(k) The Trust is clear that the Datix incident management reporting system is not to be used for highlighting issues of capability and/or suboptimal performance. However,

disciplinary action will be taken in accordance with the Trust's Disciplinary Policy if in the course of an investigation and the application of the Just Culture Guide:

(i) There is clear evidence of intended malpractice;

(ii) There is clear evidence of intended harm;

(iii) There is clear evidence of intended disregard of Trust policies and procedures;

(iv) There is clear evidence that staff are found to be deterring others from using the incident reporting system and reporting incidents.

Managers are expected to investigate all incidents in an open and constructive manner. The focus of an investigation should be on 'What is wrong?', rather than 'Who is wrong?' Managers should not, therefore, assume that disciplinary action will be the outcome but should use the Just Culture Guide in order to establish a clear picture of what happened and what went wrong.

Relationship between Reporting Incidents and other Policies

(l) The Trust Supporting Performance Policy and Procedure will be used if an individual repeatedly makes the same mistake/error and fails to learn from the support/training provided by the organisation, or where serious issues of capability are evident;

(m) If there is evidence of ill health the Supporting Attendance Policy should be used;

(n) If there is evidence of substance abuse then the Trust's Substance Misuse Policy should be consulted;

(o) Staff must be clear to differentiate between incident reporting and raising a grievance via the Trust Grievance Policy. Grievances relate specifically to employment-related matters;

(p) The Trust's Freedom to Speak Up Policy provides a mechanism for staff to raise a general concern, but should a specific incident be reported under this policy this will be investigated using a systematic approach;

(q) The Work-Related Stress Policy is designed to help managers consider possible sources of work-related pressure amongst their staff which should be considered as part of an incident investigation.

Relationship between the Dignity at Work Policy and Duty of Candour

The Trust will treat seriously, sympathetically and with an open mind any bullying and harassment allegation in relation to members of staff who may have been obstructed in exercising their duty of candour obligations as set out in this policy.

External agencies:

Managers will ensure that; where external agencies are involved in such incidents and reporting e.g. radiation protection, they are made aware of the Trust policy and do not unilaterally pursue recommendations for disciplinary action. The latter is a decision for the Trust unless there is re-course by law when an illegal act has been identified.

Appendix H –The 10 Principles of Being Open [8]

Being open involves apologising when something has gone wrong, being open about what has happened, how and why it may have happened, and keeping the patient and their family informed as part of any subsequent review.

1. Principle of Acknowledgement
All patient safety events should be acknowledged and reported as soon as they are identified. In cases where the patient, their family and carers inform healthcare employees that something has happened, their concerns must be taken seriously and should be treated with compassion and understanding by all employees. Denial of a person's concerns or defensiveness will make future open and honest communication more difficult.

2. Principles of Truthfulness, Timeliness and Clarity of Communication
Information about a patient safety incident must be given in a truthful and open manner by an appropriately nominated person. Communication should be timely, informing the patient, their family and carers what has happened as soon as is practicable, based solely on the facts known at that time. It will be explained that new information may emerge as the event investigation takes place. Patients, their families and carers and appointed advocates should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have.

3. Principle of an Apology
Patients, their families and carers should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm that has resulted from a patient safety event or that the experience was poor. Both verbal and written apologies should be offered. **Saying sorry is not an admission of liability and it is the right thing to do.** Verbal apologies are essential because they allow face to face contact, where this is possible or requested. A written apology, which clearly states the organisation is sorry for the suffering and distress resulting from the patient safety event, should also be given.

4. Principle of Recognising Patient and Carer Expectations
Patients, their families and carers can reasonably expect to be fully informed of the issues surrounding a patient safety incident, and its consequences, in a face to face meeting with representatives from the organisation and/or in accordance with the local resolution process where a complaint is at issue. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times. Patients, their families and carers should also be provided with support in a manner to meet their needs. This may involve an independent advocate or an interpreter. Information enabling to other relevant support groups will be given as soon as possible and as appropriate.

5. Principle of Professional Support
The Trust has set out to create an environment in which all employees are encouraged to report patient safety events. Employees should feel supported throughout the patient safety event

[8] (Being Open: Saying sorry when things go wrong NPSA 2009)

investigation process; they too may have been traumatised by the event. Resources available are referred to within the respective Trust policies, to ensure a robust and consistent approach to patient safety event investigation. Where there are concerns about the practice of individual employees, the Trust's Human Resources department must be contacted for advice. Where there is reason to believe an employee has committed a punitive or criminal act, the Trust will take steps to preserve its position and advise the employee at an early stage to enable them to obtain separate legal advice and/or representation. Employees should be encouraged to seek support from relevant professional bodies. Where appropriate, a referral will also be made to the Independent Safeguarding Authority.

6. Principle of Risk Management and Systems Improvement

Root Cause Analysis (RCA) or similar techniques should be used to uncover the underlying causes of patient safety events. Investigations at any identified level will, however, focus on improving systems of care, which will be reviewed for their effectiveness. *Being open* is integrated into patient safety incident reporting and risk management policies and processes.

7. Principles of Multi-Disciplinary Responsibility

Being open applies to all employees who have key roles in patient care. This ensures that the *being open* process is consistent with the philosophy that patient safety incidents usually result from system failures and rarely from the actions of an individual. To ensure multi-disciplinary involvement in the *being open* process, it is important to identify clinical and managerial leaders who will support this across the health and care agencies that may be involved. Both senior managers and senior clinicians will be asked to participate in the patient safety incident investigation and clinical risk management as set out in the respective Trust policies and practice guidance.

8. **Principles of Clinical Governance**

Being open involves the support of patient safety and quality improvement through the Trust's clinical governance framework, in which patient safety incidents are investigated and analysed, to identify what can be done to prevent their recurrence. It is a system of accountability to ensure that these changes are implemented and their effectiveness reviewed. Findings are disseminated to employees so they can learn from patient safety incidents. Audits are an integral process, to monitor the implementation and effects of changes in practice following a patient safety incident.

9. Principle of Confidentiality

Details of patient safety incidents should at all times be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the patient. The Trust will anonymise any incident it publishes but still seek the agreement of those involved.

Where it is not practicable or an individual refuses to consent to disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the patient safety event have statutory powers for obtaining information. Communications with parties outside of those involved in the investigation will be on a strictly need to know basis. Where possible, it is good practice to inform the patient, their family and carers about who will be involved in the investigations before it takes place, and give them the opportunity to raise any objections.

Consent and duty to inform for incidents involving patients in Offender Health will be dealt with in accordance with the normal prison protocol.

10. Principle of Continuity of Care

Patients will continue to receive all the usual treatment and continue to be treated with respect and compassion.

Appendix I – NHS Resolution Saying Sorry Leaflet

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

For more information on saying sorry, please see NHS Resolution’s Saying Sorry Leaflet