Sherwood Forest Hospitals NHS
NHS Foundation Trust

Title: Policy for Duty of Candour (Being Open)				
Date Approved: 14-12-2015	**Approved by:** TRUST MANAGEMENT BOARD	**Date of next review:** December 2018	**Policy Ref:** G/DOC	**Issue:** 1.2
Division/Department: Governance Support Unit		**Policy Category:** Governance		
Author (post-holder): Head of Governance, Denise Berry		**Sponsor (Director):** Executive Medical Director		

CONTENT

Amendments

Version	Issue Date	Section(s) involved	Amendment
1.2	08-05-2017	• Appendix C	• New Appendix C for SOP added
1.1	26-04-2017	• 1 – Introduction / 2 – Policy Statement (related trust policies/ guidelines)	• Sentance and link to trust's Disciplinary Policy added to strengthen link between both policies / trust's Disciplinary Policy added to list

1.0	21-12-2015	• ALL – full policy review & update	• Replaces 'Being Open' Policy

1 INTRODUCTION

The effects on patients, relatives, carers and staff, when things go wrong, can be devastating. All healthcare professionals have a duty of candour – a professional responsibility to be open and honest with patients when something goes wrong with their treatment or care, and causes, or has the potential to cause, harm or distress. All healthcare providers must promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning, matched by a commitment to being open and transparent at board level.

Since 27th November 2014, the statutory duty of candour applies to all registered providers of both NHS and independent healthcare bodies, as well as providers of social care. Regulation 20 of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014* intends to ensure that providers are open and transparent in relation to care and treatment with people who use their services, and sets out some specific requirements that providers must follow when things go wrong, including informing people about the incident, providing reasonable support, giving truthful information and apologising. Principles relating to Duty of Candour have also been written in to the latest revision of the *NHS Constitution* (July 2015).

Healthcare professionals must:

- **Tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong;**
- **Apologise to the patient (or, where appropriate, the patient's advocate, carer or family);**
- **Offer an appropriate remedy or support to put matters right (if possible);**
- **Explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long term effects of what has happened.**

Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must also be open and honest with regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns.

Any suspected breaches of the professional Duty of Candour by staff who are professionally registered will be dealt with through the policy, procedure and guidance in the trust's 'Disciplinary Policy' which may involve referral of cases to the relevant regulatory body.

2 POLICY STATEMENT

This policy is issued and maintained by the Executive Medical Director (the sponsor) on behalf of Sherwood Forest Hospitals NHS Foundation Trust ('the Trust'), at the issue defined on the front sheet, and replaces the 'Being Open Policy – A Duty to be Candid'. It addresses the Trust response to the statutory and ethical responsibility of duty of candour when a patient safety incident occurs which results in harm graded as 'moderate' or above (as defined in the Trust's Incident Reporting Policy and Procedures), and builds further on the 10 principles as stated in *'Being Open'* (National Patient Safety Agency (NPSA), 2009):

1. Acknowledgement
2. Truthfulness, timeliness and clarity of communication
3. Apology

4. Recognising patient and carer expectations
5. Professional support
6. Risk management and systems improvement
7. Multidisciplinary responsibility
8. Clinical governance
9. Confidentiality
10. Continuity of care.

The policy is designed to provide a best practice framework, based on published guidance, to create an environment where patients, their representatives and staff feel supported, and have the confidence to act appropriately, and for ensuring that all communications with relevant people are open, honest and occur as soon as possible after an event.

Equality Impact Assessment

The Trust is committed to ensuring that none of its policies, procedures and guidelines discriminate against individuals directly or indirectly on the basis of gender, colour, race, nationality, ethnic or national origins, age, sexual orientation, marital status, disability, religion, beliefs, political affiliation, trade union membership, and social and employment status. An EIA of this policy/guideline has been conducted by the author using the EIA tool developed by the Diversity and Inclusivity Committee. (03/09/2014).

Related Trust policies and guidelines and/or other Trust documents

- Claims Handling Protocol
- Complaints and Concerns Policy
- Incident Reporting Policy and Procedures
- Maternity Risk Management Strategy
- Safeguarding Adults Policy
- Safeguarding Children and Young People Policy
- Mental Capacity Act Policy
- Raising Concerns – Whistleblowing Policy
- Policy for managing staff involved in medication incidents/errors
- Confidentiality Policy
- Disciplinary Policy

3 DEFINITIONS

Trust	Sherwood Forest Hospitals NHS Foundation Trust ('the Trust')
Staff	All employees of the Trust including those managed by a third party on behalf of the Trust
Relevant person	The relevant person is the service user (i.e. 'patient' for NHS services) or, in the following circumstances, a person acting lawfully on their behalf: • on the death of the service user; • where the service user is under 16 and not competent to make a decision in relation to their care or treatment; • where the service user is 16 or over and lacks capacity (as determined in accordance with the Mental Capacity Act 2005) in relation to the matter
Notifiable safety incident	An unintended or unexpected incident that occurred in respect of the service user during the provision of regulated activity, that in the reasonable opinion of a healthcare professional, could result in, or appear to have resulted in: • The death of a service user, where the death relates directly to the incident rather than to a natural cause of the service user's illness or underlying condition; or

	• Severe harm, moderate harm or prolonged psychological harm to the service user
Severe harm	A permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition
Moderate harm	Harm that requires a moderate increase in treatment; **and** significant but not permanent harm
Harm	Any physical or mental damage or injury
Moderate increase in treatment	An unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care).
Prolonged psychological harm	Psychological harm which a service user has experienced, or is likely to experience for a continuous period of at least 28 days
Apology	An expression of sorrow or regret in respect of a notifiable safety incident
Complaint	Any expression of dissatisfaction with care provision, or a perceived grievance or injustice
NRLS	National Reporting and Learning System – the electronic system by which all NHS Trusts inform the NHS Commissioning Board Special Health Authority of patient safety incidents
CQGC	Trust Clinical Quality and Governance Committee

4 ROLE AND RESPONSIBILITIES

4.1 **The Trust Board** – actively promotes an open and fair culture that fosters peer support and discourages the attribution of blame.

4.2 **Quality Committee** – receives 6-monthly reports on compliance with the Duty of Candour regulations as part of the Trust's assurance process.

4.3 **Chief Executive Officer (CEO)** – ensures that there is Board-level public commitment to implementing the principles of 'being open' and the statutory Duty of Candour, and that the notification requirements to relevant persons are met.

4.4 **Executive Medical Director** – has responsibility for the development, implementation and enforcement of this policy, including educating healthcare professionals about 'Being Open' and the statutory Duty of Candour.

4.5 **Director of Nursing, and Clinical Directors** – are responsible for ensuring that healthcare professionals who are involved in patient safety incidents graded moderate or above are supported in the candour process, including the organisation of formal or informal debriefing of the clinical team involved in the patient safety incident, and sharing the lessons learned across the organisation.

4.7 **Governance Support Unit (GSU)** – led by the Head of Governance, the GSU has responsibility for supporting the Medical Director and Executive Director of Nursing and Quality with the implementation of the strategic and operational aspects of safety including Duty of Candour and the provision of expert advice, resources, training and education as necessary.

4.8 Patient Experience Team (PET) – have a responsibility for signposting patients, relatives and carers, and for the management of the complaints process, ensuring that complainants are listened to, an appropriate explanation sought, and that Duty of Candour principles are applied.

4.9 Head of Legal Services – is responsible for ensuring that the policy meets the statutory requirements of the Duty of Candour.

4.10 Divisional/Specialty Care group responsibility and accountability
The multi-professional team, including the lead senior clinician involved in the care of the patient, have responsibility for managing any notifiable safety incident, complaint or claim in line with relevant policy and timescales (contractual Duty of Candour requires notification of the relevant service user must be within 10 operational days of the notifiable safety incident occurring)..

4.11 All Trust staff – all staff, including temporary, agency or volunteer staff, have a responsibility for identifying actual or potential hazards, safety incidents and risks and reporting/escalating issues in accordance with this and other relevant policies. All communication with the patient, their family or carers must be explicitly and contemporaneously documented in the medical records. Healthcare professionals involved in the patients clinical care, and those with the responsibility for candour discussions may require emotional support and advice.

5 SCOPE OF POLICY

This policy applies to all staff groups, all clinical areas and all patients receiving care from the Trust, and includes any failure in care or treatment whether they are identified as a result of a:

- Patient Safety Incident (PSI)
- Concern or complaint
- Claim

6 CONSULTATION

The following individuals, groups of staff and Trust group(s)/ committee(s) have been consulted in the development/ update of this document:

Contributors:	**Communication Channel: e.g.** • **Email** • **1:1 meeting/ phone** • **Group/ committee meeting**	**Date:**
Deputy Director of Corporate Services	Meeting, email	14/10/15
Clinical Quality and Governance Committee	Committee meeting; Post-meeting email correspondence	14/10/15
Clinical Quality and Governance Committee	Re-presentation at meeting	9/12/15

7 NARRATIVE

7.1. The Trust Supports a Culture of Openness, Honesty and Transparency

The Trust supports a culture of openness, honesty and transparency in its delivery of care. This general obligation includes apologising and explaining when something goes wrong after reflection and with knowledge of all the facts.

The Trust expects all its staff members to adhere to a culture of openness and transparency.

This Policy acknowledges there are a multitude of different obligations and "Duties of Candour" (see below).

The Statutory Duty of Candour is contained within *Regulation 20 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014* ("the Regulations") and this sets out what is required of all providers, such as the Trust.

The Trust acts in line with Regulation 20 to ensure it is open and transparent with people who use services and other "relevant persons" (people acting lawfully on patients' behalf).

Reg 20 (1) states *"Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity".*

Staff must also be alive to further obligations and Duties of Candour aside from those set out under Regulation 20. Some of these obligations apply to the Trust and its staff:

The Contractual Duty of Candour (Specific Condition 35 of the Standard Contract), as between the CCG and the Trust

- Openness and Honesty when things go wrong: the professional duty of candour (http://www.gmc-uk.org/guidance/ethical_guidance/27233.asp)
- NHS Constitution (www.nhs.uk/choiceintheNHS/.../NHSConstitution/Pages/Overview.aspx)
- NHSLA "Saying Sorry leaflet" (http://www.nhsla.com/Claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf)
- Being Open (www.nrls.npsa.nhs.uk)

Others apply to healthcare professionals only (GMC and NMC Guidance):

- GMC Good Medical Practice Guidance (2013) (http://www.gmc-uk.org/guidance/good_medical_practice.asp)
- NMC Guidance –The Code: Professional Standards of Practice and behaviour for Nurses and Midwives (2015) (www.nmc.org.uk/standards/code)

This Policy therefore reflects this multitude of obligations known collectively as the "Duties of Candour".

The remainder of this Policy (Section 5.1 onwards) will refer to "notifiable safety incidents" as set out under Regulation 20. In these circumstances the Statutory Duty of Candour will apply.

There are significant sanctions for breaching any of the Duties of Candour obligations. These sanctions are set out in section 5.3.

Under Regulation 20 relevant persons must be informed of a “notifiable safety incident”. It is a mandatory field in the on-line e reporting incident form.

7.2. Process for acknowledging, apologising and explaining when things go wrong.

(See Appendix A and Appendix C)

7.2.1 Acknowledging the Event

The first step of the process is to recognise and determine whether a notifiable safety incident has occurred and whether it is appropriate to apply the Duties of Candour.

This can be identified by any of the following mechanisms including (not an exhaustive list):

- Via staff at the time of the incident.
- Via staff retrospectively.
- By the relevant person raising a concern at the time or via a complaint, whether verbal or written.
- Via the incident reporting system.
- Via the incident being reported by another patient, visitor or non-clinical staff.
- Via concerns raised by a post mortem result.
- Via concerns raised by external bodies, such as the Coroner

The Trust Risk Manager/Chief Executive Officer must be informed immediately if the notifiable safety incident was triggered by a criminal activity.

Where necessary, appropriate medical care must be given to prevent further harm.

7.2.2 Multi-disciplinary Discussions

Following identification of an incident, a preliminary team discussion should be undertaken as soon as possible to establish:

- Basic clinical facts.
- Assessment of the incident and determine level of immediate response required.
- Individual responsible for discussing/ liaising with the relevant person.
- Whether support is required for the relevant person.
- Immediate support required for staff involved.
- A clear communication plan.

The Trust expects staff to instigate and conduct a full investigation in accordance with the Trust Incident Reporting Policy and Procedures.

In line with the Trust’s culture of openness and transparency thought should be given to informing the relevant person where a “near miss” has occurred, where there has been an incident but which has caused no harm or harm which has not reached the threshold defined above.

Healthcare Professionals should use their discretion. Informing the relevant person of a near miss may aid their recovery however, it may also cause harm and distress. Advice should be sought from a senior colleague.

7.2.3 Identifying who should be responsible

It is imperative to identify the person at the Trust who will be the communicator / support / advocate for the relevant person to liaise with. Too many different individuals can cause confusion and/or upset with the potential for conflicting information and sometimes fragmentation or even overlooking opportunities. In determining who will be responsible for communicating with the relevant person the individual should:

- Have a good relationship with the relevant person
- Have a good understanding of the relevant facts.
- Be senior enough or have sufficient experience and expertise in relation to the type of incident to be credible to the relevant person
- Have excellent interpersonal skills, including being able to communicate with the relevant person in a way they can understand
- Be willing and able to offer an apology, reassurance and feedback to the relevant person
- Be able to maintain a relationship with the relevant person and to provide continued support and information.
- Be culturally aware and informed about the specific needs of the relevant person
- Be fully familiar with the obligations under the Duties of Candour
- Have the confidence to escalate any concerns and / or seek further advice where necessary

Advice and support is available from the Improving Patient Experience Team.

7.2.4 Initial discussions with the relevant person

As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred the Trust must:-

- Notify the relevant person; and
- Provide reasonable support to the relevant person in relation to the incident, including when giving such notification.

The Trust is subject to the NHS Standard Contract and must therefore ensure the notification be made within 10 operational days (an operational day is a day other than a Saturday, Sunday, or bank holiday in England) of the incident being reported to local systems, and sooner where possible.

A meeting will be necessary to notify the relevant person of the notifiable safety incident. The meeting must take place with the relevant person within 10 operational days and sooner where possible.

The following factors should be taken into account when considering the timing of the meeting:

- Clinical condition of the patient. Some relevant persons may require more than one meeting to ensure that all the information has been communicated to and understood by them
- Availability of key staff involved in the incident and in the Being Open process
- Availability of the relevant person(s).
- Availability of support staff, for example a translator or independent advocate, if required
- Patient preference (in terms of when and where the meeting takes place and who leads the discussion)
- Privacy and comfort of the relevant person
- Arranging the meeting in a sensitive location.

The notification must:

- Be given in person by one or more representatives of the Trust (This is often the most senior clinician involved in the relevant person's care - see above).
- Provide an account of all the known facts about the incident.
- Advise the relevant person that further enquiries are considered to be appropriate, and what those enquiries will be.
- Include an apology
- Be recorded in a written record which is kept securely.

In determining the manner of the notification, apology and explanation, the representative of the Trust must have due regard to Service Condition 13.2 of the Standard Condition (SC) (Equity, of Access, Equality and Non Discrimination). This stipulates there must be no discrimination on the grounds of age, disability, gender reassignment, marriage, civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other non-medical characteristics, except as permitted by the Law.

Apologies should not be formulaic but genuine. Healthcare professionals should consider the following points when communicating with a relevant person:

- Provide information in a way they can understand.
- Speak to them when they are best able to understand and retain information.
- Give a personalised apology (which must be documented in case notes).
- Tell them who to contact to ask any further questions or raise concerns.
- Tell them what steps will be taken to prevent future events reoccurring.

7.2.5 Written notification and follow-up

The Trust must ensure they give written notification (following the verbal notification) to the relevant person even though enquiries may not be complete.

Written information must include:

- All information that was included in person in the initial notification.
- An apology.
- Results of any enquiries made since the notification in person.
- The outcome and results of further enquiries must be provided to the relevant person if they wish to receive them

As, soon as practicable the relevant person must be offered a step by step explanation of events and circumstances that resulted in the incident and any pertinent information, which must be updated regularly and promptly as the investigation proceeds

Within 10 Operational Days following the investigation undertaken being signed off as complete, a copy must be shared with the relevant person.

7.2.6 Contacting the relevant person

The Trust must make every attempt to contact the relevant person through all available means of communication. All attempts to contact the relevant person must be documented. If the relevant person does not want to be contacted or informed of the notifiable safety incident, their wishes must be respected and a record must be kept. If the relevant person has died and there is nobody who can lawfully act on their behalf record must be kept.

7.2.7 Record keeping from communications with patient/relevant person

The Trust must keep a record of all communication with the relevant person.

7.2.8 Additional notifications

The Trust requires all notifiable safety incidents to be reported to Local Risk and Management systems in accordance with the Incident Reporting Policy and Procedures.

7.3. Provision of Additional Support

7.3.1 Support of the relevant person

The relevant person should be provided with support as is necessary/reasonable during the process of notification, written notification and follow up. At any face to face meeting, they should be encouraged to be accompanied by another family member / friend / representative. Where appropriate, an independent advocate or interpreter should be offered. The relevant person is also at liberty to request a second or independent review and this should be facilitated.

Where a relevant person has died or is unlikely to regain consciousness information should be conveyed in a compassionate way. The healthcare professional must show respect to bereaved people and take into account any known wishes of the relevant person when they were alive. This includes what should happen upon their death and who information is shared with. Bereaved people should be helped with administrative tasks.

7.3.2 Information on how relevant persons can access additional support services

The relevant person can be offered additional support from:

- Governance Support Unit can be contacted on internal extension 6301
- Patient Experience Team can be contacted on internal extension 3588
- Interpretation services via :- 08081890108

- Chaplaincy via internal extension 3047 (Kings Mill) and 5643 (Newark)

External bodies which may be able to provide support for the relevant person include:

- CAS - Independent Complaints Advocacy Services
- CRUSE (bereavement counselling support)
- IMCA – Independent Mental Capacity Advocate Service

7.3.3 Where the patient is assessed not to have capacity

Where the relevant person has undergone a mental capacity assessment and is found to lack capacity, the principles of Duties of Candour still apply. In circumstances where the relevant person has a health and welfare lasting power of attorney ("LPA"), it may be a legal requirement that they are informed (dependent on the terms of the LPA).

In this case the Attorney(s) under the LPA would be deemed the relevant person. If there is no LPA for the relevant person, it is best practice that other relevant persons (i.e. family/carers) are informed of the incident unless the relevant person has previously indicated they do not want particular other relevant persons involved in their healthcare. In this situation the family member/s would be considered the relevant person. The occurrence of this conversation and the grounds for it must be recorded in the relevant person's medical record.

Healthcare professionals should consider involving the Independent Mental Capacity Advocacy Service (IMCA) at any notification or follow-up meeting where the relevant person lacks capacity. The purpose of the Independent Mental Capacity Advocacy Service is to help particularly vulnerable people who lack the capacity to make important decisions and who have no family or friends that it would be appropriate to consult about those decisions. The role of the Independent Mental Capacity Advocate (IMCA) is to work with and support people who lack capacity, and represent their views to those who are working out their best interests. A copy of "Making Decisions - The Independent Mental Capacity Advocate Service" can be obtained from the following link:
https://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/making-decisions-opg606-1207.pdf

7.3.4 Children and young people

A young person (anyone aged 16-17) is presumed capable of consenting to their own medical treatment in line with the Mental Capacity Act 2005. However, it is still considered to be good practice to encourage the young person to involve their family.

The Courts have stated that children under 16 years old who understand fully what is involved in the proposed procedure can also give consent. This is sometimes known as Gillick competence. 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 notification process after a notifiable safety event.

The opportunity for the person with parental responsibility (usually the 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

person with parental responsibility (usually parents) alone or in the presence of the child.

In these instances, the parents' or person with parental responsibility's views on the issue should be sought. In these instances the person with parental responsibility is the relevant person.

7.3.5 Maternity

It is important to remember that in maternity services there may be occasions when a high degree of sensitivity is required when considering the Duties of Candour notification. This situation can occur for example following an unexpected intrauterine fetal death or stillbirth or an unexpected admission to the neonatal unit. In these instances timing of the notification should be determined by the staff caring for her but must be within 10 operational days.

7.3.6 Relevant persons with a mental disorder

The only circumstances in which it is appropriate to withhold a notifiable safety incident from a relevant person with a mental disorder 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 a second opinion (by another consultant psychiatrist) would be needed to justify withholding information from the relevant person.

Only in exceptional circumstances is it appropriate to discuss a notifiable safety incident with a representative of the relevant person without their express permission.

Staff are advised to discuss such a proposed action with a senior member of the Governance Support Unit and Caldicott Guardian. Any decision to withhold information on these grounds should be clearly recorded in the medical records.

7.3.7 Relevant persons with learning disabilities

Some relevant persons with Learning Disabilities may need some additional support to understand the Duties of Candour and notification process. All attempts should be made to include the relevant person in the process by use of reasonable adjustments such as: additional time to understand the process, alternative communication methods (use of easier reading information, pictures/symbols, use of everyday simple language), support in understanding by involving family members or familiar workers, use of an advocate to ensure the relevant person's views are considered and discussed. If the mental capacity of a relevant person is in question then a formal assessment of mental capacity should be undertaken and section 7.3.3 above should be followed.

7.3.8 Relevant persons with different language or cultural considerations

The need for translation and advocacy services and consideration of special cultural needs (such as for relevant persons 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 a notifiable safety event information. It would be worthwhile to obtain advice from an advocate or translator before the meeting on the most sensitive way to discuss the information. Avoid using unofficial translators and/or the relevant person's

family or friends. Information can be found on the intranet on how to contact the Trust's contracted "Interpreting and Translation Services". A code will be required to use the telephone interpreting services (0808 189 0108) – the Out Patient Clinics, Wards and some departments already have codes. For general enquiries please contact the trust's management team/ patient services secretarial team on ext 3831, 3368, 4168.

7.3.9 Relevant persons with different communication needs

A number of relevant persons will have particular communication difficulties, such as a hearing impairment. Plans for the notification meeting should fully consider these needs. Knowing how to enable or enhance communications with a relevant person is essential to facilitating effective Duties of Candour and notification. This involves focussing on the needs of the relevant person and being personally thoughtful and respectful. For Information on how to contact the interpreting and translation service, see section above.

7.3.10 Legal affairs

Where the Duties of Candour raises specific ethical or legal considerations, the Department of Legal Affairs can be contacted for advice via internal extension 3257.

7.3.11 Professional support

It can be very traumatic for healthcare staff to be involved in a notifiable safety incident. The Trust is committed to ensuring staff feel supported through the process. Staff are also encouraged to seek support from their relevant professional body. (See the Trust's 'Supporting Staff Involved in Incidents, Complaints or Claims Policy' for further details).

The Trust will:

- Actively promote an open and fair culture that fosters peer support and discourages blame.
- Educates all staff on the Duties of Candour.
- Provide facilities for formal and informal debriefing.
- Provide opportunities within the clinical schedule for staff to discuss the matter.
- Provide advice and training on the management of notifiable safety events.
- Provide information and support systems to support staff who have, been distressed by incidents.
- Develop specific system of support through staff support services and senior clinical counsellor.

Additional, confidential support is available to staff from:

- Occupational Health via internal ext. 5135
- Chaplaincy via internal ext. 3047 (Kings Mill) and 5643 (Newark)
- Governance Support Unit ext. 6301
- Staff are encouraged, if appropriate to seek advice from their trade union representative.

Staff will not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or threat to their registration. Where there is evidence to believe that punitive disciplinary action may follow or criminal act has occurred, the NPSA Incident Decision Tree should be used to ensure a robust and consistent approach. The Incident Decision Tree aims to help the NHS move away from attributing blame and instead find the cause when things go wrong. The goal is to promote fair and consistent staff treatment within and between healthcare organisations. Further information can be found in Appendix B.

Incidents relating to employee performance or conduct should be referred to the appropriate divisional human resources (HR) advisor and managed in accordance with Trust disciplinary and performance management procedures.

7.3.12 Risk management and systems improvement

The Trust supports the root cause analysis (RCA) approach to looking at the causes of notifiable safety events. The focus is on improving systems of care. Further details are available in the 'Incident Reporting Policy and Procedures'.

7.3.13 Multi professional responsibility

The Trust acknowledges that relevant person care is delivered through multi professional teams and the investigation into a notifiable safety event, complaint or claim is focused on systems and processes, rather than individuals. For this reason, senior clinicians and managers must participate in the investigation process.

Senior Healthcare Professionals must also:

- Have responsibility to encourage openness and honesty in reporting notifiable safety incidents and near misses. Clinical leaders should foster a culture of learning and improvement.
- Ensure systems are in place to give early warning signs of any failure or potential failure in the clinical performance of individual in the team.
- Ensure systems including auditing are in place to monitor, improve and review the quality of the team's work.

However, in line with both the NMC and GMC Guidance all healthcare professionals must fully co-operate in any investigation undertaken by the Trust.

If an expert opinion is sought, individuals must declare any conflict of interest.

7.3.14 Confidentiality

Details surrounding a notifiable safety event are confidential. Full consideration should be given to maintaining the confidentiality of the patient, carers and staff involved, in line with the 'Confidentiality policy'.

It is good practice to inform the relevant person about who will be involved in the investigation, and give them opportunity to raise any objections. Communication outside the clinical team should be strictly on a 'need to know' basis. Equally the relevant person may need specific questions answered by the investigation process and should be given the opportunity to raise these.

7.3.15 Continuity of care

Relevant persons have the right to expect that their care will continue, and that they will receive all their usual treatment with the care, respect and dignity that they are entitled to. If the relevant person has a preference for their care to be delivered by another team, the appropriate arrangements should be made.

Further, any notifiable safety incident should be communicated to the relevant person's GP if they are going to be receiving on-going care in the community.

7.3.16 Requirements for documenting all communication

All discussions and communication with the relevant person should be carefully detailed in the medical case notes. Additionally, in reviewing the care the interaction with the relevant person should be detailed within the investigation report.

Where the communication happens as part of the complaints or claims process, this should be documented within the case file.

Where it occurs as the result of a notifiable safety incident, this will be recorded within the investigation report.

7.3.17 Process for encouraging open communication between organisations, teams, staff, relevant persons.

Where the notifiable safety incident, complaint or claim involves outside agencies (e.g. other healthcare providers, the Commissioners or social services) whether raised by The Trust or the other agency, there is an obligation to fully co-operate with them and to communicate collaboratively with them.

7.4. Sanctions for non-compliance with the duty of candour

Various sanctions apply for non-compliance with the Duties of Candour.

7.4.1 Statutory Duty of Candour

It is a criminal offence not to notify the relevant person of a notifiable safety incident or fail to meet the requirements for such notification. If the Trust is found guilty of such an offence, they will be liable to conviction of a fine not exceeding £2,500. The CQC can prosecute without serving written notice first. A fixed penalty of £1,250 may be offered by the CQC as an alternative to prosecution.

7.4.2. Contractual Duty of Candour

If there is a breach of the contractual Duty of Candour to notify relevant persons of a suspected or actual patient safety incident the commissioning body can recover from the Trust either the cost of the episode of care or up to £10,000 if the cost is unknown.

Where a Trust breaches any requirement there are a range of actions available for the commissioner:

- Requiring a direct written apology and explanation for the breach to the individual from the Trust's Chief Executive Officer.
- Publication of the breach on the Trust's website.
- Notification to the CQC by commissioners.

7.4.3 Breach of NMC/GMC Guidelines

A breach of GMC/NMC Guidance can lead to professional regulatory proceedings being bought against the Healthcare Professional. This can result in conditions being attached to a healthcare professionals' registration or removal of licence.

8 EVIDENCE BASE

1. The NHS Constitution (amendment July 2015)
2. NHS Standard Contract: Contractual Duty of Candour (since April 2013)
3. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
4. Care Quality Commission Regulation 20: Duty of Candour (March 2015)
5. Openness and honesty when things go wrong: the professional duty of candour (GMC and NMC Joint Statement, June 2015)
6. Being Open (NPSA, 2004, reissued November 2009)
7. NHSLA (May 2009) Apologies and Explanations

9 MONITORING COMPLIANCE

Compliance with the policy will be monitored through the use of feedback forms and via the review of closed serious incident investigation files. Completion of compliance monitoring forms is undertaken by the GSU at the conclusion of the case, in conjunction with the Trust Patient Safety Lead, and forms part of the core case file.

Any identified areas of non-adherence or gaps in assurance rising from the monitoring of this policy will result in recommendations and proposals for change. Monitoring of these recommendations and proposals will be co-ordinated by the group/committee as identified in the table below:

Element of policy to be monitored	Lead	Tool / Method	Frequency	Owner	Reporting route
Process for encouraging open communication	Head of Governance/ Patient Safety Lead	Audit of mandatory field on the e-reporting form	Annual	Datix® administrator	CQGC
		Review of all RCAs from SI Scoping and Sign-Off groups, to provide assurance that the patient has been told and what has been shared.	Bi-weekly post each SI Scoping and SI Sign-Off meeting	Patient Safety Lead	

Process for acknowledging, apologising and explaining when things go wrong	Head of Governance/ Patient Safety Lead	Audit of mandatory field on the e-reporting form	Annual	Datix® administrator	CQGC
		Review of all RCAs from SI Scoping and Sign-Off groups	Bi-weekly post each SI Scoping and SI Sign-Off meeting	Patient Safety Lead	
Element of policy to be monitored	**Lead**	**Tool / Method**	**Frequency**	**Owner**	**Reporting route**
Requirements for truthfulness, timeliness and clarity of communication	Head of Governance/ Patient Safety Lead	Audit of mandatory field on the e-reporting form	Annual	Datix® administrator	CQGC
		Review of all RCAs from SI Scoping and Sign-Off groups	Bi-weekly post each SI Scoping and SI Sign-Off meeting	Patient Safety Lead	
Provision of additional support as required	Head of Governance/ Patient Safety Lead	Audit of mandatory field on the e-reporting form	Annual	Datix® administrator	CQGC
		Review of all RCAs from SI Scoping and Sign-Off groups	Bi-weekly post each SI Scoping and SI Sign-Off meeting	Patient Safety Lead	
Requirements for documenting all communication	Head of Governance/ Patient Safety Lead	Audit of mandatory field on the e-reporting form	Annual	Datix® administrator	CQGC
		Review of all RCAs from SI Scoping and Sign-Off groups	Bi-weekly post each SI Scoping and SI Sign-Off meeting	Patient Safety Lead	
All requirements as above, in the event of a complaint or claim, to be monitored via questionnaire	Head of Customer Services/Legal Services Manager	Questionnaire at case closure	Annually to CQ&GC	Patient Experience Manager/Legal Services Manager to compile report	Trust Management Board

10 TRAINING REQUIREMENTS

- Duty of Candour forms part of the syllabus for all Trust Root Cause Analysis (RCA) training courses.
- Duty of Candour is included in Trust induction for all Registered Nurses and Midwives.
- Doctors in training must evidence their training progression irrespective of grade via their e-portfolio's and one of the criteria listed is professionalism. All trainees are aware of the GMC Duty of Candour Guidelines to which this criterion is referenced.
- Duty of Candour training provision for existing Trust staff as part of the mandatory update programme is yet to be developed and implemented.

11 DISTRIBUTION

Following formal approval, this policy will be published to and form part of the Trust's suite of 'Governance Policies' accessible to all staff.

Once published, information regarding its issue will be emailed by the Head of Governance to the following staff for information, dissemination and action as needed:

- Divisional Governance Groups
- Specialty Governance Groups
- (see below for all methods of communication)

12 COMMUNICATION

- A news item will be posted on the INTRANET to raise awareness of the revised policy
- A news item will be included in the monthly 'Staff Briefings'
- An article to be placed in the Trust safety newsletter, 'Safety Matters'
- This document will appear in the 'New and Updated' area of the Intranet
- This document will be both consulted and communicated via the Divisional Governance meetings and cascaded to specialty governance meetings
- Via the Medical Managers forum
- Via the Senior Nurse Forum
- The investigation report template guidance has been revised and is inclusive of the principles of '*Policy for Duty of Candour (Being Open)'*

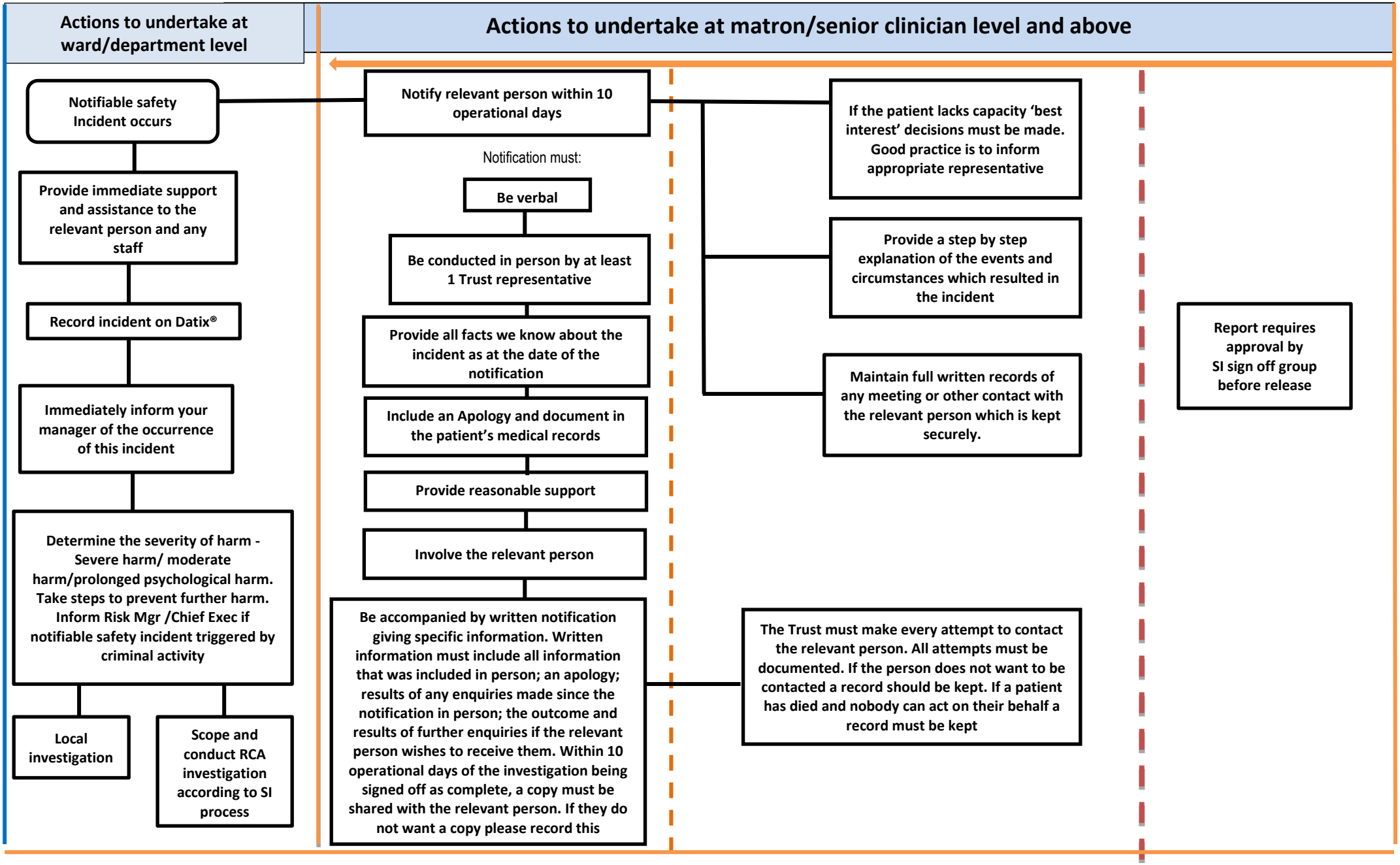
13 AUTHOR AND REVIEW DETAILS

Issue/ Version:	1.2
Date issued:	8th May 2017
Date to be reviewed by:	December 2018
To be reviewed by:	Head of Governance/ Martin Bullock
Executive Sponsor:	Executive Medical Director
Supersedes: **(Ref No., Version number, previous title if changed, date issued – review date)**	Policy for Duty of Candour (Being Open) v1.1 Issued 26th April 2017 (updated) to RV Dec 2018

14 APPENDICES

Appendix A – Flowchart to ensure Duties of Candour is followed for every Moderate, Severe and Death PSI
Appendix B – Incident Decision Tree (NPSA 2005)
Appendix C – Duty of Candour – Standard Operating Procedure (***Hyperlinked to intranet***)

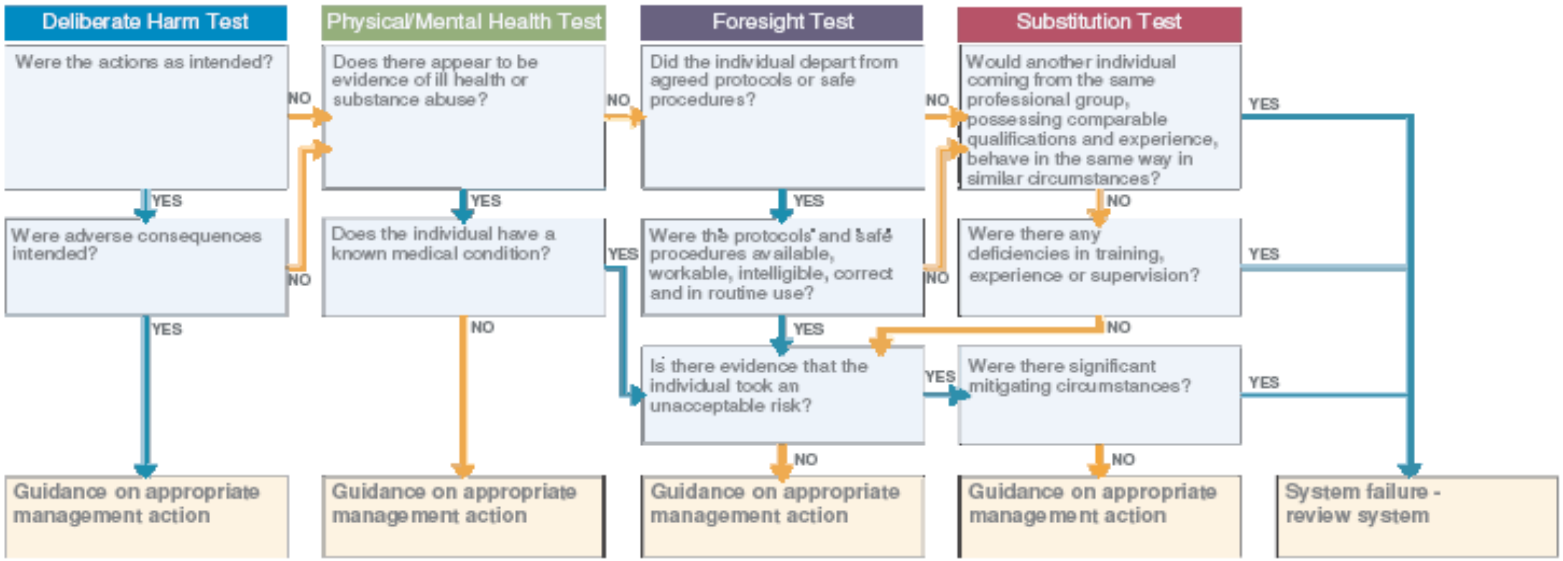
Appendix A – Flowchart to ensure Duties of Candour is followed for every Moderate, Severe and Death PSI



Appendix B

Incident Decision Tree

National Patient Safety Agency



Based on James Reason's Culpability Model. © National Patient Safety Agency 2005