South London and Maudsley NHS Foundation Trust

POLICY ON BEING OPEN AND DUTY OF CANDOUR

Version:	5
Ratified By:	Clinical Policy Working Group
Date Ratified:	1st June 2018
Date Policy Comes Into Effect:	18th June 2018
Author:	Myrna Harding, Trust Investigation Facilitator
Responsible Director:	Michael Holland, Medical Director
Responsible Committee:	Health, Safety and Fire Committee
Responsible Committee Approval Date:	14th June 2018
Target Audience:	All Trust Staff
Review Date:	June 2021

Equality Impact Assessment	Assessor: Myrna Harding	Date: 14.06.18
HRA Impact Assessment	Assessor: Myrna Harding	Date: 29.03.18

Document History

Version Control

Version No.	Date	Summary of Changes	Major (must go to an exec meeting) or minor changes	Author
1.0	September 2008	Newly introduced policy.	Major	David Watts, Assistant Director of Patient Safety
2.0	December 2009	Monitoring requirements amended. Policy amended in response to changes in incident terminology.	Major	David Watts, Assistant Director of Patient Safety
3.0	30 April 2011	Monitoring requirements amended. Amendments made in response to Trust reconfiguration and policy template changes.	Major	David Watts, Assistant Director of Patient Safety
3.1	24th October 2011	Application of Policy in relation to grading of complaints clarified on page 5 (following Being Open Audit).	Minor	David Watts, Assistant Director of Patient Safety
3.2	23rd November	Minor amendments to monitoring table	Minor	David Watts, Assistant Director of Patient Safety
4.0	July 2011	Policy amended in response to introduction of contractual requirement of Duty of Candour	Major	Myrna Harding, Trust Investigation Facilitator
5.0	May 2018	Formal review	Major	Myrna Harding, Trust Investigation Facilitator

Consultation

Stakeholder/Committee/ Group Consulted	Date	Changes made as a result of consultation
Medical Director	March 2018	None
Director of Nursing	March 2018	None
All Trust Service Directors	March 2018	Amendments to references to CAGs / Operations Directorates
Patient Safety Team	March 2018	None
Clinical Policy Working Group	1st June 2018	Equality Impact Assessment
Health, Safety and Fire Committee	14th June 2018	None

Plan for Dissemination of Policy

Audience(s)	Dissemination Method	Paper or Electronic	Person Responsible
All Senior Managers and Core Standard Leads	A group email will be sent alerting teams to the policy and instructing them to download for local use	Electronic	Myrna Harding, Trust Investigation Facilitator
Partner Agencies and Stakeholder	Email	Electronic	Myrna Harding, Trust Investigation Facilitator

Plan for Implementation of Policy

Details on Implementation	Person Responsible
Training on policy to be included in the Practical Guide to Structured Investigations Training	Myrna Harding, Trust Investigation Facilitator and Abigail Fox-Jaeger, Trust Investigation Facilitator
Quarterly Learning Lessons Events to include information on the policy	Patient Safety Team
Uploading policy on Trust intranet	Clinical Policy Co-ordinator

Contents

1. Introduction

In September 2005 the National Patient Safety Agency (NPSA) issued a Safer Practice Notice advising all NHS organisations to implement a Being Open Policy. In November 2009 a Patient Safety Alert was issued by the NPSA to ensure that providers of NHS funded care implemented the principles of Being Open. Compliance with the requirements is subject to assessment by the NHS Litigation Authority. The NHS Standard Contract 2013-14 (Annex 4) specifically requires NHS provider organisations to implement and measure the principles of Being Open under a contractual Duty of Candour. In addition, the Francis Report (2013) makes recommendations with regard to Openness, Transparency and Candour.

This policy describes how South London and Maudsley NHS Foundation Trust (SLaM) will demonstrate its openness with service users and relatives when mistakes are made. Being Open is a set of principles that healthcare staff should use when communicating with service users, their families and carers following an incident in which the service user was harmed. The specific delivery of *Being Open* communications will vary according to the severity grading, clinical outcome and family arrangements of each specific event. The Duty of Candour applies to those patient safety incidents which result in none / insignificant harm, low harm, moderate harm, severe harm or death.

The Trust aims to promote a culture of openness, which it sees as a prerequisite to improving patient safety and the quality of service user experience.

This policy is to be implemented following all patient safety incidents where moderate, severe harm or death has occurred.

Being open relies initially on staff and the rigorous reporting of patient safety incidents. The Trust endorses the Francis Report Recommendation 173:

'*Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be open, honest and truthful.'*

Therefore, staff who are concerned about the non-reporting or concealment of incidents, or about ongoing practices which present a serious risk to patient safety, are encouraged to raise their concerns under the Trust's Whistleblowing Policy

2. Scope

This document outlines the Trust's policy on openness and how SLaM meets its obligations to service users, relatives and the public by being open and honest about any mistakes that are made whilst Trust staff care for and treat service users.

This document is aimed at all staff working within the Trust and sets out the infrastructure which is in place to support openness between healthcare professionals and service users, their families and carers, following a patient safety incident.

3. Objectives

The objectives of this policy are to evidence that a robust risk management system is in place which reflects the following:

3.1 A patient has a right to expect openness from their healthcare providers.

3.2 The Trust will learn from mistakes with full transparency and openness.

3.3 A proactive approach to patient safety with the onus on risk management systems and processes identifying incidents which require review and learning.

3.4 Working in partnership with all stakeholders

3.5 Staff do not intend to cause harm but unfortunately incidents do occur. When mistakes happen, service users /relatives / carers / others should receive an apology and explanation as soon as possible. Saying sorry is not an admission of liability and staff should feel able to apologise at the earliest opportunity.

3.6 Senior managers undertaking serious incident investigations must follow the SLaM Policy for the Investigation of Incidents, Complaints and Claims. They must ensure that appropriate support is offered to the service user / families / carers / others. A single point of contact will be identified with the service user / carer / relative to maintain communication and feedback of information about the incident.

3.7 Line managers should understand that an individual or team may require support during the investigation and, after discussion, should guide them to the appropriate support mechanism. This will include contact details of both external and internal support. Please refer to the Trust Supporting Staff Policy.

4. Definitions

NB: Being Open and Duty of Candour applies principally to incidents but they may lead to secondary complaints and claims that should be treated in the same way.

The term **patient safety event** is used in this policy to cover patient safety incidents, complaints and claims.

A **patient safety incident** is *'any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS funded healthcare'*[1]

A **complaint** is an expression of dissatisfaction received by the Trust verbally or in writing either directly from or on behalf of service users, their families and carers.

A **claim** is a request for compensation.

The term **None / Insignificant Harm** is any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS funded care and any patient safety incident that ran to completion but no harm occurred to people receiving NHS funded care.

The term **Low Harm** is any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS funded care.

The term **Moderate Harm** is any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

The term **Severe Harm** is any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.

[1] National Patient Safety Agency: Seven Steps to Patient Safety (2004)

The term **Death** is any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care.

Openness – enabling concerns and complaints to be raised and disclosed freely without fear, and for questions to be answered.

Transparency – allowing information about the truth about performance and outcomes to be shared with service users, the public and regulators.

Candour – any service user harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked. (Francis 2013)

5. Summary of the development of the Being Open and Duty of Candour Policy including consultation and communication with stakeholders

This policy has been formulated to reflect the increased focus and need for openness. The NHS Standard Contract 2013-14 (Annex 4) specifically requires NHS provider organisations to implement and measure the principles of Being Open under a contractual Duty of Candour. The Francis Report (2013) makes recommendations with regard to Openness, Transparency and Candour. The GMC / NMC publication of 2015 (Openness and honesty when things go wrong – the professional duty of candour) outlines the responsibilities of registered professionals to comply with the duty of candour.

The Trust Patient Safety Team developed the policy in conjunction with colleagues from the Legal Services, Complaints and Information Governance departments.

The ratified policy will be circulated to partner agencies and stakeholders.

6. The ten principles of Being Open (including the process for acknowledging, apologising and explaining when things go wrong)

Being Open is a process rather than a one-off event. It is a process underpinned by ten principles promoted in the National Patient Safety Agency (NPSA) publication *'Being Open: Communicating patient safety incidents with patients and their carers'* (NPSA (2009)) which informs the rationale for improving communication between NHS staff and patients. The principles are summarised in Appendix 2 of this policy.

7. Duties within the organisation

This section gives an overview of the individual, departmental and committee roles and levels of responsibility for ensuring open and honest communication with service users and / or relevant others.

The Trust Chief Executive

The Trust Chief Executive is ultimately responsible for ensuring that incidents, complaints and claims are effectively reported and investigated and that an acknowledgement, apology and explanation is provided to those involved.

Directors and senior managers

Directors and senior managers must ensure that communication and management systems are in place to enable front line staff to provide care as safely as possible in accordance with Trust policies and procedures.

Directors and senior managers have a responsibility to foster a culture of openness. They should ensure that staff are supported and have the confidence to report and

acknowledge patient safety events and provide an apology and explanation to service users and / or relevant others. Opportunities for staff to undertake relevant Being Open training should also be in place.

Directors and senior managers must ensure that staff follow the principles of being open and the duty of candour and are aware of the risks to the Trust if they do not do so.

The Patient Safety, Complaints, PALS and Legal Services Departments
These central Trust departments have a responsibility to ensure that open communication is promoted at all times. This will be achieved by:

- Ensuring all patient safety incidents, complaints and claims are monitored.
- Prompting and reminding staff about their responsibilities to be open in response to patient safety events.
- Ensuring that the DATIX electronic reporting system is used to its full potential to ensure that key documents are attached and fields completed.
- Processing information consistently and precisely and presenting it in a timely, relevant and meaningful way. This information can be presented through feedback to directorates and teams, annual reports and aggregated reports (for further information refer to the Policy on the Process for the Aggregation of Incidents, Claims and Complaints.

Staff with responsibility for service user care
All Trust staff responsible for service user care should acquaint themselves with the policy and understand the procedures for Being Open and Duty of Candour. Staff should ensure that patient safety events are acknowledged and reported as soon as they are identified.

The Trust Quality Committee
The main role of the committee is to provide assurance to the Board of Directors on the delivery of the Trust's Quality Strategy. It will have a role in examining where there have been failures in service or clinical quality and monitor progress against action plans to address them. It meets monthly and is chaired by a Non-Executive Director and is responsible to the Trust Board.

The Serious Incident Review Group
The main role of this group is to provide assurance to the Board of Directors that investigations into serious incidents are robust. The investigation reports include details of whether the Duty of Candour has been followed. It meets monthly and is chaired by the Director of Nursing and is responsible to the Trust Quality Committee.

The Trust Board
The Trust Board have responsibility to obtain assurance that the processes work effectively to support the Board level public commitment to implementing the *Being Open* principles and Duty of Candour and are aware of the risks if the Trust does not do so.

8. The detection and recognition of patient safety events

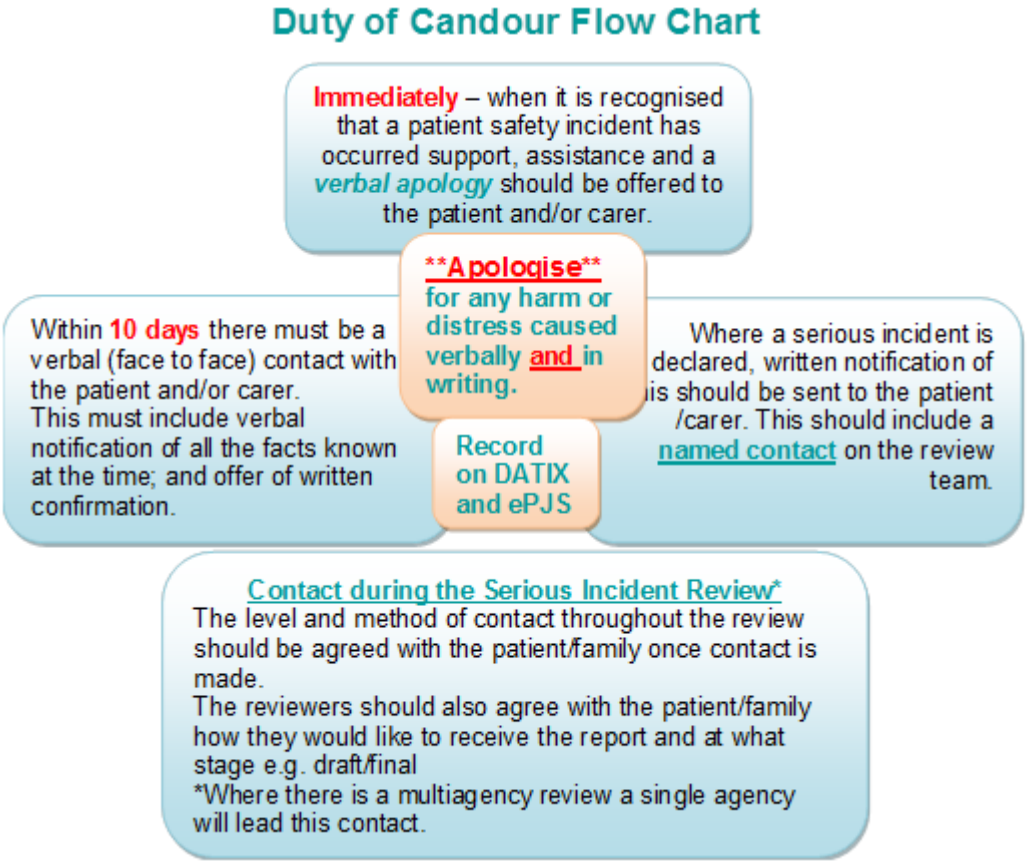
The being open and duty of candour process begins with the recognition that a service user and / or relevant other has been involved in a patient safety event. A patient safety event may be identified by:

- a member of staff at the time of the incident;
- a member of staff retrospectively when an unexpected outcome is detected;
- a service user and / or relevant other who expresses concern or dissatisfaction with the service user's healthcare either at the time of the patient safety event or retrospectively;
- incident detection systems such as incident reporting or medical records review;

- other sources such as detection by other service users, visitors or non-clinical staff.

As soon as a patient safety event is identified, the priority is to provide prompt and appropriate clinical care and prevent further harm. An electronic DATIX incident form should be completed in accordance with the Trust Incident Policy**.** Key staff will then receive an automatic incident alert. This notification system ensures that key staff quickly become aware of an incident and enables a preliminary discussion to establish the facts of the case and to identify the timely and planned response to the service user and / or relevant others.

9. The Being Open and Duty of Candour procedure



9.1 The service user or their family / carer must be informed that a suspected patient safety incident has occurred within at most **10 working days** of the incident being reported to the local systems, and sooner where possible. This should be done by the ward consultant (for an inpatient) or the Community Mental Health Team Leader (for a community patient).

9.2 The initial notification must be verbal and face to face where possible and will be followed by a letter from a senior directorate manager.

9.3 An apology must be provided – a sincere expression of sorrow or regret for any suspected harm caused must be provided verbally and in writing.

9.4 If the service user / family or carer is already aware of the incident then the immediate actions as stated above should be followed by a letter. The letter should be sent to the service user and / or relatives and others inviting them to meet with the nominated staff, offering them a choice of venues and times and advising of the independent advocacy service available to support and assist them (in accordance with the Trust's Complaints Policy.

The service user and / or relatives and others should be given the opportunity to choose:
Whom they would prefer to meet with;
Where and when the meeting will be held;
Whether they would like to bring someone with them to the meeting;
The date, time and venue should be confirmed in writing.

9.5 Responsible staff may continue to meet with the service user / relatives and others to support continuity of communication and relationship building.

9.6 The meeting is held as soon as possible after the incident, taking into account the service user's and / or the relative's and others wishes.

9.7 Any meeting should be held in deference to the service user's / relatives / advocate's wishes. The same applies to any venue; it is usually for the service user / relative to decide and for the Trust to accommodate.

9.8 The directorate management team will be kept up to date on progress with the investigation and contacts with the service user and family.

9.9 Should the Trust become aware of a patient safety incident which has taken place and the service user and family are not aware then steps 8.1 to 8.8 will be followed and the letter will be signed by the directorate Director.

Each patient safety event is different and for this reason the roles and responsibilities outlined in this section are meant as a guide. Service users, staff and relevant others will respond differently to a patient safety event and for this reason roles and responsibilities will often be identified and confirmed on a case-by-case basis.

The Trust aims for openness and has the intention of disclosing as much information as possible. In certain cases some information may be withheld or restricted, for example where:

- the information might adversely affect the health of the patient;
- specific legal requirements preclude disclosure for specific purposes;
- there is a danger of adverse repercussions for Trust staff.

In such cases advice will be sought, for example, from the Metropolitan Police and NHS London.

The Head of Patient Safety is responsible for ensuring that letters of apology and condolence (where appropriate) are sent. The 'extra fields' section on the DATIX database has a section to record whether the letter of condolence has been sent – this will be confirmed by relevant staff in each directorate upon receipt of a copy of the letter.

Communication should be clear, sympathetic and effective throughout all stages of the being open and duty of candour process. Appropriate language should be used and jargon and abbreviations should be avoided.

10. Communication and follow up meetings with the service user and / or relevant others

Being open is not a one-off event and follow-up meetings, which are a requirement of the process, should be arranged to ensure the service user and / or relevant others are kept informed and updated. The service user and / or relevant others should be given the opportunity to raise concerns and issues as and when necessary. Meetings should be held when there is important information to report and should take the form most acceptable to the service user and / or relevant others.

10.1 Procedure for the nominated investigation team

When a Level 1 or Level 2 investigation is required, a structured investigation will be undertaken (Please see Trust policy for the Investigation of Incidents, Complaints and Claims).

At the meeting with the service user and / or relatives and others, the investigation team should follow the procedure below:

Apologise for what happened;

If known, explain what went wrong and where possible, why it went wrong;

Give the service user and / or relatives an opportunity to ask as to why they thought it went wrong and an error occurred. This may include relevant personal circumstances should staff agree these can be shared;

Inform the service user and / or relatives and others what steps are being / will be taken to prevent the incident recurring;

Provide an opportunity for the service user and / or relatives and others to ask any questions;

Agree with the service user and / or relatives and others any future meetings as appropriate;

Suggest any sources of additional support and counselling and provide written information if appropriate;

The investigation team is responsible for keeping the service user / relatives and others up to date with how the investigation is progressing, maintaining a dialogue by addressing new concerns, sharing new information when available and providing information on counselling as appropriate;

At the conclusion of the investigation, the investigation team should offer to meet with the service user and / or relatives to provide feedback on the findings of the investigation. The directorate Service Director responsible for implementing any changes as specified in the investigation report's action plan should also be present at the meeting;

Records of any meetings will be created and maintained by the investigation team.

10.2 Completing the Being Open and Duty of Candour process

The investigation feedback meeting to the service user and / or relatives will take place within 10 days of the completed structured investigation being signed off by within the Trust. This should include the full written report and action plans. The feedback meeting is an opportunity to have a frank and open discussion of the findings and the lessons learnt.

The following information will be provided at the meeting:

- An outline of the chronology of care and a summary of the factors that contributed to the incident;
- An outline of the findings and lessons learnt;
- A repeated apology for any shortcomings in the delivery of care that led to the patient safety incident and the distress that has been caused
- Information on what has been and will be done to avoid recurrence of the incident and how these improvements will be monitored.

- Details of where the service user and / or relatives can seek further support.

11. Requirements for documenting all communication

The requirements for documenting all communication are set out below:

- the record of an open and honest apology;
- sharing any facts that are known and agreed with the service user / carers;
- an invitation to the service user / carers to participate in the investigation and to agree how they will be kept informed of the progress and results of that investigation;
- an explanation of any likely short and long-term effects of the incident;
- a clear response to questions the service user / carer may have;
- an offer of appropriate practical and emotional support to the service user / carer;
- The documentation arising from the being open and duty of candour process (for example completed incident forms, statements, mediated meeting notes) should be held on a central file (Datix). The documentation should not be held on the patient's ePJS record.

12. Confidentiality and Effective Information Sharing

Trust staff have a common law duty of confidentiality to service users and are expected to handle personal confidential information of service users in accordance with the Data Protection Act (1998) and the Caldicott Principles. The key principles staff need to follow in relation to service user confidentiality is outlined in the Trust's Confidentiality Policy.

Caldicott and Data Protection Principles are not an obstacle to sharing information. The statute and relevant Trust policies provide the framework for staff to share information effectively to ensure service users receive the most appropriate and safest treatment and care from the Trust's clinical services. Staff have a duty of confidentiality to service users which is a competing duty to the duty to share information effectively. The Trust's Information Sharing Policy outlines key principles when making decisions about sharing information in order to strike the right balance.

It is of crucial importance that staff understand their legal responsibilities and duties in relation to respecting service user confidentiality whilst sharing information about their care in a lawful and fair way. The Data Protection Act and the Caldicott Principles provide a helpful framework to enable an ongoing and mutually beneficial relationship and communication with carers and family members. Staff are expected to understand service users' wishes in relation to sharing information with carers and must respect their wishes. At times when service users refuse to share information with their carers and family members despite a good history of relationship, staff are expected to outline the advantages of sharing information effectively. The Trust has developed guidance on sharing information with carers and families, which is part of the Confidentiality Policy. The document provides helpful guidance on strategies staff may follow when service user / carer relationships break down.

13. Monitoring Compliance

What will be monitored i.e. measurable policy objective	Method of Monitoring	Monitoring frequency	Position responsible for performing the monitoring/ performing co-ordinating	Group(s)/committee(s) monitoring is reported to, inc responsibility for action plans and changes in practice as a result
Process for encouraging open communication between healthcare organisations, healthcare teams, staff, patients and/or their carers	Audit	Annual	Head of Patient Safety	Trust Quality Committee
Process for acknowledging, apologising and explaining when things go wrong	Audit	Annual	Head of Patient Safety	Trust Quality Committee
Requirements for truthfulness, timeliness and clarity of communication	Audit	Annual	Head of Patient Safety	Trust Quality Committee
Requirements for documenting all communication	Audit	Annual	Head of Patient Safety	Trust Quality Committee
Breaches of the requirements of Duty of Candour	Audit	Annual	Head of Patient Safety	Trust Quality Committee

14. Associated Documentation

- Risk Management and Assurance Strategy
- Investigation of Incidents, Complaints and Claims Policy
- Incident Policy
- Complaints Policy
- Claims Handling Policy
- Supporting Staff Involved in Incidents, Complaints and Claims
- Policy on the Process for the Aggregation of Incidents, Claims and Complaints
- Whistleblowing Policy

- Information Sharing Policy
- Confidentiality Policy
- Implementation of National Guidance in SLAM Policy
- Learning from Embedding Lessons Arising from Incidents, Complaints and Claims
- 2013/14 NHS Standard Contract – Technical Contract Guidance
- Seven Steps to Patient Safety – NPSA (2004)
- National Framework for Reporting and Learning from Serious Incidents Requiring Investigation - NPSA (2013)
- The Francis Inquiry Report (2013)
- The Data Protection Act (1988)
- The Caldicott Principles (1997)
- Openness and Honesty When Things Go Wrong – The Professional Duty of Candour (2015)

Trust intranet web page links

Structured Investigations:
http://sites.intranet.slam.nhs.uk/si/default.aspx

Patient Safety:
http://sites.intranet.slam.nhs.uk/risk/default.aspx

Complaints:
http://sites.intranet.slam.nhs.uk/complaints/default.aspx

Claims and Legal:
http://sites.intranet.slam.nhs.uk/claime/default.aspx

Clinical Governance:
http://sites.intranet.slam.nhs.uk/cg/default.aspx

Health & Safety:
http://sites.intranet.slam.nhs.uk/healthandsafety/default.aspx

Child Protection - Safeguarding Children:
http://sites.intranet.slam.nhs.uk/childprotection/default.aspx

Supporting Staff involved in Incidents, Complaints and Claims
http://sites.intranet.slam.nhs.uk/risk/supportstaff/default.aspx

15. References

Associated external web sites:

National Patient Safety Agency:
http://www.npsa.nhs.uk/

National Health Service Litigation Authority:
http://www.nhsla.com/home.htm

General Medical Council
http://www.gmc-uk.org/

Nursing and Midwifery Council
http://www.nmc-uk.org/

Department of Health

http://www.dh.gov.uk

Care Quality Commission:
http://www.cqc.org.uk/

NHS England:
http://www.england.nhs.uk

The Francis Inquiry Report:
http://www.parliament.uk

2013/14 NHS Standard Contract – Technical Contract Guidance:
http://www.england.nhs.uk/wp-content/uploads/2013/02/contract-tech-guide.pdf

16. Freedom of Information Act 2000

All Trust policies are public documents. They will be listed on the Trusts FOI document schedule and may be requested by any member of the public under the Freedom of Information Act (2000).

Appendix 1

The Ten Principles of Being Open

1. **Principle of acknowledgement**

   All patient safety events should be acknowledged and reported as soon as they are identified. The concerns of those involved must be taken seriously and should be treated with compassion and understanding by staff. Denial of a person's concerns will make future open and honest communication more difficult.

2. **Principle of truthfulness, timeliness and clarity of communication**

   Information about a patient safety event must be given in a truthful and open manner by an appropriately nominated person. Communication should be timely, informing the service user and / or relevant others what has happened as soon as is practicable, based solely on the facts known at that time. Explain that new information may emerge as an incident investigation takes place and that they will be kept up to date. Service users and / or relevant others should receive clear, unambiguous information and be given a named point of contact for any questions or requests they may have.

3. **Principle of apology**

   Service users and / or relevant others 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. This should be in the form of an appropriately worded apology as early as possible. Both verbal and written apologies should be given. Verbal apologies are essential because they allow face-to-face contact. A written apology, which clearly states the organisation is sorry for the suffering and distress resulting from the patient safety event must also be given.

4. **Principle of recognising service user, family and carer expectations**

   Service users and / or relevant others can reasonably expect to be fully informed of the issues surrounding a patient safety event, and its consequences, in a face-to-face meeting with representatives of the Trust. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times. Service users and / or relevant others should also be provided with support in a manner to meet their needs. This may involve an independent advocate or interpreter. Information on the Patient Advice and Liaison Service (PALS) and other relevant support groups should be given as soon as possible.

5. **Principle of professional support**

   Staff are encouraged to report patient safety incidents and should feel supported throughout the investigation process. Further information about the support given to staff is contained in the Policy for Supporting Staff Involved in Incidents, Complaints and Claims. Where there is reason for the Trust to believe a member of staff has committed a punitive or criminal act, steps will be taken to preserve its position and advise the member of staff at an early stage to enable them to obtain separate legal advice and / or representation. Staff should be encouraged to seek support from relevant professional bodies.

6. **Principle of risk management and systems improvement**

The Trust uses systematic investigation techniques and tools to assist in uncovering the underlying causes of patient safety events. The investigation will focus on learning lessons and improving systems of care. Further information about the investigation process can be found in the Policy for the Investigation of Incidents, Complaints and Claims.

7. Principle of multi-disciplinary responsibility

The Being Open and Duty of Candour Policy applies to all staff responsible for the care of service users. Most healthcare provision involves multi-disciplinary teams and communication with service users and / or relevant others following a patient safety event should reflect this. This will ensure 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. Managers will champion the Being Open process to help ensure multidisciplinary involvement and the identification of staff who are able to undertake the role of the named point of contact for service users and / or relevant others.

8. Principle of clinical governance

Being Open requires the support of patient safety and quality improvement through clinical governance frameworks to learn what can be done to prevent their recurrence. It also involves a system of accountability through the Trust Chief Executive to the Trust Board to ensure these changes are implemented and their effectiveness reviewed. These findings should be disseminated to staff so they can learn from patient safety incidents. Some of the mechanisms through which this is achieved are outlined below:

- Trust wide committees
- Directorate panels and committees
- Annual serious incident, complaints and claims reports
- Aggregated (learning lessons) report on incidents, claims and complaints
- Audits undertaken to monitor the implementation and effects of key changes in practice following a patient safety investigation.

9. Principle of confidentiality

Details of a patient safety event should always be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the service users. Where this is not practicable or an individual refuses consent to the disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the incident have statutory powers for obtaining information. Communications with parties outside of the clinical team should also be on a strictly need to know basis and where practicable records should be anonymous. It is good practice to inform the service user and / or relevant others about who will be involved in the investigation before it takes place, and give them the opportunity to raise any objections.

10. Principle of continuity of care

Service users are entitled to expect they will continue to receive all usual treatment and continue to be treated with respect and compassion. If a service user expresses a preference for their healthcare needs to be provided by another team there should be serious consideration of this request.

APPENDIX 2: EQUALITY IMPACT ASSESSMENT

PART 1: Equality relevance checklist

The following questions can help you to determine whether the policy, function or service development is relevant to equality, discrimination or good relations:

- Does it affect service users, employees or the wider community? Note: relevance depends not just on the number of those affected but on the significance of the impact on them.
- Is it likely to affect people with any of the protected characteristics (see below) differently?
- Is it a major change significantly affecting how functions are delivered?
- Will it have a significant impact on how the organisation operates in terms of equality, discrimination or good relations?
- Does it relate to functions that are important to people with particular protected characteristics or to an area with known inequalities, discrimination or prejudice?
- Does it relate to any of the following 2013-16 equality objectives that SLaM has set?
    1. All SLaM service users have a say in the care they get
    2. SLaM staff treat all service users and carers well and help service users to achieve the goals they set for their recovery
    3. All service users feel safe in SLaM services
    4. Roll-out and embed the Trust's Five Commitments for all staff
    5. Show leadership on equality though our communication and behaviour

Name of the policy or service development: Policy on Being Open and Duty of Candour

Is the policy or service development relevant to equality, discrimination or good relations for people with protected characteristics below?

Please select yes or no for each protected characteristic below

Age	**Disability**	**Gender re-assignment**	**Pregnancy & Maternity**	**Race**	**Religion and Belief**	**Sex**	**Sexual Orientation**	**Marriage & Civil Partnership** *(Only if considering employment issues)*
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

If yes to any, please complete Part 2: Equality Impact Assessment

If not relevant to any please state why:

Date completed: 14 June 2018

Name of person completing: Myrna Harding

Operations Directorate/CAG: Nursing Directorate

Service / Department: Patient Safety Team

Please send an electronic copy of the completed EIA relevance checklist to:

1. macius.kurowski@slam.nhs.uk

PART 2: Equality Impact Assessment

1. Name of policy or service development being assessed?

Policy on Being Open and Duty of Candour

2. Name of lead person responsible for the policy or service development?

Myrna Harding, Trust investigation Facilitator

3. Describe the policy or service development

What is its main aim?

The policy describes how South London and Maudsley NHS Foundation Trust (SLaM) will demonstrate its openness with service users and relatives when mistakes are made. Being Open is a set of principles that healthcare staff should use when communicating with service users, their families and carers following an incident in which the service user was harmed. The specific delivery of *Being Open* communications will vary according to the severity grading, clinical outcome and family arrangements of each specific event. The Duty of Candour applies to those patient safety incidents which result in none / insignificant harm, low harm, moderate harm, severe harm or death.

The Trust aims to promote a culture of openness, which it sees as a prerequisite to improving patient safety and the quality of service user experience.

What are its objectives and intended outcomes?

The objectives of this policy are to evidence that a robust risk management system is in place which reflects the following:

3.1 A patient has a right to expect openness from their healthcare providers.

3.2 The Trust will learn from mistakes with full transparency and openness.

3.3 A proactive approach to patient safety with the onus on risk management systems and processes identifying incidents which require review and learning.

3.4 Working in partnership with all stakeholders

3.5 Staff do not intend to cause harm but unfortunately incidents do occur. When mistakes happen, service users /relatives / carers / others should receive an apology and explanation as soon as possible. Saying sorry is not an admission of liability and staff should feel able to apologise at the earliest opportunity.

3.6 Senior managers undertaking serious incident investigations must follow the SLaM Policy for the Investigation of Incidents, Complaints and Claims. They must ensure that appropriate support is offered to the service user / families / carers / others. A single point of contact will be identified with the service user / carer / relative to maintain communication and feedback of information about the incident.

3.7 Line managers should understand that an individual or team may require support during the investigation and, after discussion, should guide them to the appropriate support mechanism. This will include contact details of both external and internal support. Please refer to the Trust Supporting Staff Policy.

What are the main changes being made?

Formal policy review resulting in minor changes in response to updated external guidance.

Key changes include

- Update format to improve usability
- QI methodology
- Changes in the organisations structure for the management and investigation of incidents

What is the timetable for its development and implementation?

Ratification of revised policy in June 2018

4. What evidence have you considered to understand the impact of the policy or service development on people with different protected characteristics?

(Evidence can include demographic, ePJS or PEDIC data, clinical audits, national or local research or surveys, focus groups or consultation with service users, carers, staff or other relevant parties).

Demographic information is collected on Datix from entries made on ePJS therefore the impact would be similar. Some thematic reviews of the representation of people with specific protected characteristics who are involved in serious incidents e.g. a review of the frequency of violent incidents on female and male wards. This highlighted no evidence of over reporting or underreporting that may have been indicative of a negative effect associated with incident reporting.

5. Have you explained, consulted or involved people who might be affected by the policy or service development?

Service users have been involved in the development of this policy but were not specifically consulted during this review. The principles of this policy underpin periodic Learning Events facilitated by the Patient Safety Team. Learning from workshops at these events (including a recent once focused on Families and Carers) has been fed into this review.

Consultation has taken place with the relevant Trust Leads as outlined on pages 3 and 4 of the policy. Amendments have been made in line with feedback.

6. Does the evidence you have considered suggest that the policy or service development could have a potentially positive or negative impact on equality, discrimination or good relations for people with protected characteristics?

Age	**Positive impact:** Yes	**Negative impact:** No
Please summarise potential impacts:		
Disability	**Positive impact:** Yes	**Negative impact:** Yes
Please summarise potential impacts: Patients / families / carers are sent a letter by the investigation team inviting them to participate in the investigation. However the investigation team may be unaware whether the contents of the letter are understood and are accessible by the recipient.		
Gender re-assignment	**Positive impact:** Yes	**Negative impact:** No
Please summarise potential impacts:		
Race	**Positive impact:** Yes	**Negative impact:** No

Please summarise potential impacts:		
Pregnancy & Maternity	**Positive impact:** Yes	**Negative impact:** No
Please summarise potential impacts:		
Religion and Belief	**Positive impact:** Yes	**Negative impact:** Yes
Please summarise potential impacts: It may be that due to certain cultural beliefs, patients / families / carers may be unable to participate in the investigation.		
Sex	**Positive impact:** Yes	**Negative impact:** No
Please summarise potential impacts:		
Sexual Orientation	**Positive impact:** Yes	**Negative impact:** No
Please summarise potential impacts:		
Marriage & Civil Partnership *(Only if considering employment issues)*	**Positive impact:** Yes	**Negative impact:** No
Please summarise potential impacts:		
Other (e.g. Carers)	**Positive impact:** Yes	**Negative impact:** No
Please summarise potential impacts:		

7. Are there changes or practical measures that you can take to mitigate negative impacts or maximise positive impacts you have identified?

YES: The investigation team can check on ePJS and the patient's care team whether there would be any limits to the patient / family / carer participating in the investigation.

8. What process has been established to review the effects of the policy or service development on equality, discrimination and good relations once it is implemented?

(*This may should include agreeing a review date and process as well as identifying the evidence sources that can allow you to understand the impacts after implementation)*

There will continue to be ad hoc thematic reviews undertaken prior to the next planned review in 2021. The Patient Safety Team plan to put systems in place to capture this learning more effectively.

Lessons Learned events provide an opportunity to review the effects of the Patient Safety pathway on people with protected characteristics – such an event is scheduled for 2019.

Date completed: 14 June 2018

Name of person completing: Myrna Harding

Operations Directorate/CAG: Nursing Directorate

Service / Department: Patient Safety Team

Please send an electronic copy of your completed action plan to:

1. macius.kurowski@slam.nhs.uk

PART 3: Equality Impact Assessment Action plan

Potential impact	Proposed actions	Responsible/ lead person	Timescale	Progress
Monitor actual equality impacts of the policy	Continue to build awareness of the organisational pressures that can contribute to over generalisation about groups with certain with protected characteristics	Patient Safety Team	On-going	
	Put systems in place to capture learning of factors relating to equality or protected characteristics emerging from incident investigations more effectively.	Patient Safety Team	On-going	
	Review the effects of the Patient Safety pathway on people with protected characteristics in lessons learnt events	Patient Safety Team	Dec 2019	
Review actual equality impacts of policy	Review EIA	Policy Lead	Aug 2021	

Date completed: 14 June 2018

Name of person completing: Myrna Harding, Investigation Facilitator

Operations Directorate/CAG: Nursing Directorate

Service / Department: Patient Safety Team

Please send an electronic copy of your completed action plan to:

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Appendix 3 – Human Rights Act Assessment

To be completed and attached to any procedural document when submitted to an appropriate committee for consideration and approval. If any potential infringements of Human Rights are identified, i.e. by answering Yes to any of the sections below, note them in the Comments box and then refer the documents to SLaM Legal Services for further review.

For advice in completing the Assessment please contact Paul Bellerby, Legal Services [paul.bellerby@slam.nhs.co.uk]

HRA Act 1998 Impact Assessment	Yes/No	If Yes, add relevant comments
The Human Rights Act allows for the following relevant rights listed below. Does the policy/guidance NEGATIVELY affect any of these rights?		
Article 2 - Right to Life [Resuscitation /experimental treatments, care of at risk patients]	No	
• Article 3 - Freedom from torture, inhumane or degrading treatment or punishment [physical & mental wellbeing - potentially this could apply to some forms of treatment or patient management]	No	
• Article 5 – Right to Liberty and security of persons i.e. freedom from detention unless justified in law e.g. detained under the Mental Health Act [Safeguarding issues]	No	
• Article 6 – Right to a Fair Trial, public hearing before an independent and impartial tribunal within a reasonable time [complaints/grievances]	No	
• Article 8 – Respect for Private and Family Life, home and correspondence / all other communications [right to choose, right to bodily integrity i.e. consent to treatment, Restrictions on visitors, Disclosure issues]	No	
• Article 9 - Freedom of thought, conscience and religion [Religious and language issues]	No	
• Article 10 - Freedom of expression and to receive and impart information and ideas without interference. [withholding information]	No	
• Article 11 - Freedom of assembly and association	No	
• Article 14 - Freedom from all discrimination	No	

Name of person completing the Initial HRA Assessment:	Myrna Harding
Date:	29.03.18
Person in Legal Services completing the further HRA Assessment (if required):	Not applicable
Date:	Not applicable