

## Duty of Candour Policy

***Please be aware that this printed version of the Policy may NOT be the latest version. Staff are reminded that they should always refer to the Intranet for the latest version.***

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1	Nov 14	5	Duty of Candour (DOC)definition	April 15
2	Nov 14	6	Duty of Candour explanation	April 15
3	Nov 14	11	Clinical risk manager responsibilities	April 15
4	Nov 15	4	Introduction	Nov 15
5	Nov 15	6	SIRI - reporting	Nov 15
6	Nov 15	11	SHA changed to CCG.	Nov 15
7	Nov 15	11	Title change of risk and Litigation manager	Nov 15
8	Nov 15	12	Title change of risk and litigation manager.	Nov 15
9	Nov 15	14	Reconfigured appendix 1	Nov 15.
10	Nov 15	8	Non Registered staff guidance re DoC	Nov 15.
11	Jan 16		Appendix 6: Duty of Candour Template Letters	Jan 16

**Review Log**

Include details of when the document was last reviewed:

Version Number	Review Date	Lead Name	Ratification Process	Notes
3	April 2015	Emergency Planning Lead	Through the Policy Group	Changes made to include the new statutory duty of candour

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## EXECUTIVE SUMMARY

The effects on patients, relatives, carers and staff, when things go wrong, can be devastating. 'Duty of Candour' outlines the principles that healthcare staff should use when communicating with patients, their families, next of kin and carers following a patient safety incident, complaint or claim (hereafter referred to as the 'event') where a patient was harmed, or where there is a risk or possibility that the event could lead to or result in harm to a patient. It underpins a culture of openness, honesty and transparency and is a duty on the organisation as a whole as well as individual practitioners working within the organisation in accordance with their own code of practice, ie the NMC, GMC and HCPC. Individual practitioners should refer to their own code of conduct in this respect. The duty of candour is therefore a parallel duty on Solent NHS Trust and individual practitioners working within the trust.

## WHAT IS 'DUTY OF CANDOUR'

This is a contractual duty under the Health and Social Care Act 2014 requiring Trusts to ensure that patients/families are informed of incidents causing moderate, severe harm or death and then providing them with support. This includes not only physical harm but psychological harm that could have been caused to a patient. The duty encompasses informing the service user or their next of kin that an incident has occurred, that it is being investigated, confirming this in writing, supporting them, apologising informing them of the outcome of the investigation and actions to prevent recurrence in future and how these are being shared within the trust and in a wider context.

***A breach in the Duty of Candour can result in a fine and is enforceable by the Care Quality Commission (CQC).***

## 1 INTRODUCTION

1.1 Every Healthcare Professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause harm or distress (physical and psychological). This means that the healthcare professionals must:

- tell the patient (or, where appropriate, the patient's advocate, carer or family) when something goes wrong
- apologise to the patient (or, where appropriate, the patients advocate, carer or family)
- offer an appropriate remedy or support to put matters right (if this is 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, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising a concern.

## 2. SCOPE & DEFINITIONS

### 2.1 Scope

- 2.1.1 This document applies to all directly and indirectly employed staff within Solent NHS Trust and other persons working within the organisation in line with Solent NHS Trust's Equal Opportunities Document.
- 2.1.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff.
- 2.1.3 The policy is also required to be followed by Independent Contractors.
- 2.1.4 Solent NHS Trust require all groups of independent contractors to adopt the policy of duty of candour with patients following adverse events where patients have been harmed or where there is a possibility or risk of harm having occurred.
- 2.1.5 This policy is intended for all staff and particularly those who may come in to contact with individuals and/or their families or carers following an adverse event (including Complaints and Litigation Claims – for further information please refer to these policies).
- 2.1.6 The Trust is committed to fulfil its obligation around 'Duty of Candour' by communicating with patients, their relatives and carers about any failure in care or treatment, whether they be the results via a
- Patient Safety Incident (PSI)
  - Complaint
  - Claim
- 2.1.7 This policy deals with the information and methods of sharing that information with patients, relatives and their carers, next of kin, staff and other healthcare organisations. It will be enacted depending on the grading of the severity of the event. Further information on the grading of harm is contained in the table in Appendix 1.

## 2.2 Purpose

- 2.2.1 The purpose of this policy is to provide a best practice framework, based on the guidance of the National Patient Safety Agency (NPSA), 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.

## 2.3 Definitions

- 2.3.1 **Claim** – defined by the Clinical Negligence Scheme for Trust (CNST) as: *“any demand, however made, but usually by the patient's legal adviser, for monetary compensation in respect of an adverse clinical incident leading to a personal injury”*.
- 2.3.2 **Complaint** – defined as any expression of dissatisfaction, or a perceived grievance or injustice.
- 2.3.3 **Event** – Any occurrence that results in a patient safety incident, complaint or claim.
- 2.3.4 **Patient Safety Incident** – Is an unintended or unexpected incident which could have or did lead to harm (physical or psychological) for one or more patients.

- 2.3.5 **'No harm'** – The incident had potential to cause harm, but harm was prevented, and no harm was caused to the patient OR the incident was not prevented, but no harm came to the patient,
- 2.3.6 **'Low harm'** – Any patient safety incident that required extra observation, or minor treatment and caused minimal harm to one or more patients.
- 2.3.7 **'Moderate harm'** – Any patient safety incident that required extra observation or minor treatment and caused minimal harm to one or more patients.
- 2.3.8 **'Severe harm'** – Any patient safety incident that appears to have resulted in permanent harm-related directly to the incident and not to the natural course of the patient's illness or underlying condition.
- 2.3.8(a) **'Moderate harm' and 'Severe harm'** includes physical and psychological harm that has or could arise in future from a patient safety incident.
- 2.3.9 **'Death'** – Death must be related to the incident rather than the underlying condition or illness.
- 2.3.10 **'Duty of Candour'** – is triggered when there is:
- Death or severe harm
  - **"moderate harm"** when there is
    - (a) a moderate increase in treatment (moderate increase in treatment means a 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);
    - (b) significant, but not permanent, harm.
  - A possibility that either or any of the above could occur or arise in future.
- 2.3.11 **'Duty of Candour breach'** – is when the organisation has not informed the patient or their next of kin, of the harm that has occurred within the time scales.
- 2.3.12 **Near Miss / Potential Incident** is defined as any incident/occurrence which, but for luck or skilful management, would in all probability resulted in an adverse outcome or a prevented patient safety incident.
- 2.3.13 **Never Event** – Are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by the healthcare provider.
- 2.3.14 **NRLS** – National Reporting and Learning System – the electronic system by which all NHS Trusts inform the NPSA of patient safety incidents.
- 2.3.15 **NPSA** – (National Patient Safety Agency) An arms length body of the Department of Health (DH)
- 2.3.16 **SIRI** - Serious Incident Requiring Investigation is any incident occurring in relation to care that is reportable to the Clinical Commissioning Groups/ NHS England. Further explanation can be found within the Incident Reporting and Management Policy.

### 3. DUTY OF CANDOUR

- 3.1 The Duty of Candour will apply to moderate, severe harm or death incidents

- **The duty is: Regulation 20(1)** The health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying out a regulated activity.
- **Regulation 20(2)**As soon as practicable after becoming aware that a notifiable safety incident has occurred a health service body must
  - (a) notify the relevant person that the incident has occurred, and
  - (b) provide reasonable support to the relevant person in relation to the incident, including when giving such notification
- **How is the duty achieved Regulation 20(3)**The notification to be given must:
  - (a) be given in person by one or more representatives of the service line.
  - (b) provide an account, which to the best of the service’s knowledge is true, includes all the facts the service provider knows about the incident as at the date of the notification,
  - (c) advise the relevant person what further enquiries into the incident are appropriate,
  - (d) include an apology, and
  - (e) be recorded in a written record which is kept securely.

**Further actions:**

Consideration should be given to what support might be offered to the patient:

- Pastoral support at the meeting and afterwards may be required
- An identified single point of contact post meeting
- Information about broader support
- Treatment to reduce the harm caused
- Transfer to another clinical team or even another provider, if requested
- Ensure documentation around these discussions and ongoing correspondence is held securely.

#### **4. PROCESS/REQUIREMENTS FOR BEING OPEN AND DUTY OF CANDOUR**

##### **4.1 Process for acknowledging, apologising and explaining when things go wrong (see appendix 2 and 3 for guidance and support)**

4.1.1 The first step of the process is the recognition of an incident and when the level of harm dictates that it is appropriate to apply Duty of Candour.

4.1.2 This can be identified by any of the following mechanisms:

- Via staff at the time of the incident
- Via staff retrospectively
- By the patient/family/carer raising a concern, either at the time, or via a complaint or claim in retrospect
- Via the incident reporting system
- Via other sources, such as the incident being highlighted by another patient, visitor or non-clinical staff
- Via concerns raised following a post mortem result

4.1.3 Where necessary, immediate clinical care should be given to prevent further harm.

- 4.1.4 Following identification of an incident, a preliminary discussion should be undertaken between the Service and the Clinical Risk and Safety Manager to establish:
- Basic clinical facts
  - Assessment of the incident and determine level of immediate response required
  - Individual responsible for discussing/liasing with the patient/relative/carer
  - Whether patient support (e.g. Patient experience team) is required
  - Immediate support required for staff involved
  - A clear communication plan
- 4.1.5 **The service is responsible for contacting the Clinical Risk and Safety Manager to hold this discussion via the telephone or email.**
- 4.1.6 In determining who will be responsible for communicating with the patient/family/carers the individual should:
- Have a good relationship with the patient and/or their carers
  - 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 patients, carers and colleagues
  - Have excellent interpersonal skills, including being able to communicate with patients and/or their carers in a way they can understand and avoiding excessive use of medical jargon
  - Be willing and able to offer an apology, reassurance and feedback to patients and/or their carers
  - Be able to maintain a relationship with the patient and/or their carers and to provide continued support and information
  - Be culturally aware and informed about the specific needs of the patient/relatives or their carers
- 4.1.7 Advice and support is available from the Quality and Professional Standards team if required.
- 4.1.8 The initial Duty of Candour discussion with the patient and/or their carers should occur as soon as possible after recognition of the incident. Non Registered Staff should provide an initial apology that the incident has occurred to the patient and/or their carers and then ensure they handover to a Health Care Professional at the earlier opportunity. It is important to note that saying sorry is not an admission of guilt but is an empathic response.
- 4.1.9 Factors to consider when timing this discussion include:
- Reasonable assurance that the facts are known and understood
  - Clinical condition of the patient. Some patients 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 Duty of Candour process
  - Availability of the patient's family and/or carers
  - 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 patient
  - Arranging the meeting in a sensitive location
- 4.1.10 Following any investigation the outcome must then be communicated with the patient/service user or their family.

## **4.2 Risk Management and Systems improvement**

- 4.2.1 Solent NHS Trust supports the root cause analysis (RCA) approach to looking at the causes of patient safety incidents. The focus is on improving systems of care. Further details are available in the *'Incident Reporting and Management Policy'*.

## **4.3 Multi-professional responsibility**

- 4.3.1 Solent NHS Trust acknowledges that patient care is delivered through multi-professional teams and the investigation into a patient safety incident/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.

## **4.4 Confidentiality**

- 4.4.1 Details surrounding an event are confidential. Full consideration should be given to maintaining the confidentiality of the patient, carers and staff involved, in line with the *'Data protection policy'*.
- 4.4.2 It is good practice to inform the patient, their family and carers 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 relatives may need specific questions answered by the investigation process and should be given the opportunity to raise these.

## **4.5 Continuity of care**

- 4.5.1 Patients 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 patient has a preference for their care to be delivered by another team, where possible, the appropriate arrangements should be made.

## **4.6 Requirements for documenting all communication**

- 4.6.1 All discussions and communication with the patient, their family or carers should be carefully detailed in the patient clinical records. Additionally, in reviewing the care for that patient, the interaction with the patient, their family or carers should be detailed within the investigation report.
- 4.6.2 Where the communication happens as part of the complaints or claims process, this should be documented within the case file.
- 4.6.3 Where it occurs as the result of a patient safety incident, this will be recorded within the investigation report.

## **4.7 Process for encouraging open communication between organisations, teams, staff and patients/carers**

- 4.7.1 Where the incident, complaint or claim involves outside agencies (e.g. other healthcare providers, the clinical commissioning group or social services) whether raised by Solent NHS Trust or the other agency, there is an obligation to fully co-operate with them and to communicate collaboratively with them. If the patient is receiving shared care i.e. residential

care, it is the Trust's responsibility to ensure that duty of candour is discussed with the other provider to ensure it has been met.

## 5. ROLES & RESPONSIBILITIES

- 5.1 **All Staff**, including temporary, agency or volunteer staff, will follow the requirements of this policy where they are involved in any form of communication with the affected individual and/or the person's carers or relatives, following an adverse event or reported concern about an individual's safety. This includes ensuring that appropriate reporting of the event takes place in accordance with Solent NHS Trust policies and procedures and maintaining a record of all communications made with the person and/or the person's carers or relatives.
- 5.2 **Managers and Supervisors** must ensure that all staff are aware of this policy and follow its process/requirements. This includes ensuring appropriate staff attendance at training where this is identified as necessary. They will communicate with the Clinical Risk and Safety Manager to ensure that the organisation is aware of the incident and the following decisions and actions.
- 5.3 Managers should support staff to ensure they are **not unfairly** exposed to disciplinary action, increased medico-legal risk or any threat to their registration.
- 5.4 **Directors** will ensure that appropriate Liaison Officers are identified, where this is thought advisable for the incident, and review the on-going appropriateness of the assigned individual during any investigations that may be required.
- 5.5 The **Chief Executive** has overall responsibility on behalf of Board for the adherence to duty of candour in Solent NHS Trust.
- 5.6 The **Legal Services Manager** will work with the appropriate Director where there has been an event or litigation claim to identify whether this may warrant a Liaison Officer to be appointed in order to coordinate local correspondence with the affected person.
- 5.7 **Line Managers** are responsible for ensuring that the Duty of Candour training is mandatory in the induction of all new Trust staff.
- 5.8 **Appointed Liaison Officers** will ensure that the principle processes described in this policy and other relevant policies are followed at all stages of communication with the person affected and/or their relatives or carers and, where applicable, taking account of the guidance provided. Detailed records of all such communication made by all healthcare staff involved must be retained and made available for any investigation processes.
- 5.9 **Clinical Risk and Safety Manager** will ensure that the appropriate senior staff are informed of any breach of the Duty of Candour. It is essential that all communication with the patient, their family or carers be fully and explicitly documented as soon as possible after the discussion is held.
- 5.10 **Associate Director of Workforce and Development** will ensure that mandatory training is available for all staff.

## 6. TRAINING

- 6.1 Mandatory training will be available for all staff on Duty of Candour through Learning and Development.

## **7. EQUALITY & DIVERSITY AND MENTAL CAPACITY ACT**

- 7.1 Solent NHS Trust embraces and accepts its legal, social and moral responsibilities in relation to equality and diversity. The organisation is committed to delivering equality of opportunities for service users, carers and staff and to the wider communities it serves.
- 7.2 An Equality Impact Assessment has been undertaken and is attached at Appendix 5. Solent NHS Trust is not aware of any negative impact of this policy.

## **8. SUCCESS CRITERIA / MONITORING THE EFFECTIVENESS OF THE DOCUMENT**

- 8.1 The Legal Services Manager will monitor the number and value of litigation claims against the Trust arising from patient safety adverse events and other adverse events and will provide a report on findings and any lessons to be learned as part of the Risk Management Annual Report.

## **9. REVIEW**

- 9.1 This document may be reviewed at any time at the request of either at staff side or management, but will automatically be reviewed three years after initial approval unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

## **10. LINKS TO OTHER DOCUMENTS**

1. Step 5 of *Seven steps to patient safety*, 'Involve and communicate with patients and the public',
2. National Health Service Litigation Authority (NHSLA) circular 02/2002 updated August 2007 referencing s.2. Compensation Act 2006
3. The Chief Medical Officer's consultation document, *Making Amends*
4. General Medical Council (GMC), *Good Medical Practice* guide
5. Department of Health (DH) Duty of Candour consultation 2012
6. Parliamentary and Health Service Ombudsman (PHSO) Principles of good complaint handling (2008)
7. Nursing Midwifery Council (NMC) Openness and honesty when things go wrong: the professional duty of candour (2015)

This Policy links with:

Confidentiality Policy  
Complaints Policy  
Safeguarding Children & Young Adults Policy  
Safeguarding Vulnerable Adults Policy  
SIRI Policy  
Deprivation of Liberty Safeguards and Mental Capacity Act Policy  
Data Protection Policy  
Disciplinary Policy  
Managing Performance of Medical and Dental Staff policy  
Performance Management policy  
Consent to Examination & Treatment Policy  
Claims Policy

Investigation Policy  
 Incidents and Near Misses Policy  
 Risk Management Strategy  
 Records Management & Lifecycle Policy  
 Freedom of Information Policy  
 Policy for Supporting Staff in giving statements and attending court hearings and inquests.

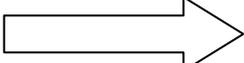
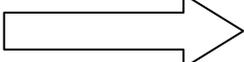
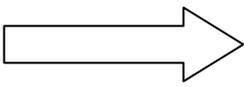
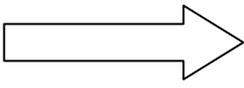
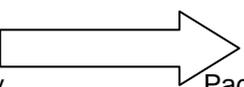
**APPENDIX 1**

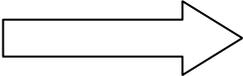
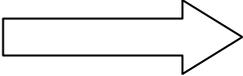
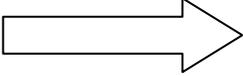
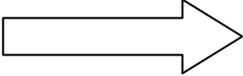
**NPSA Terms and Definitions for Grading Patient Safety Incidents**

Grade of patient safety incident	Definition
No harm <b>Insignificant (1)</b>	<ul style="list-style-type: none"> <li>• <b>Incident prevented</b> – any patient safety incident that had the potential to cause harm but was prevented, and no harm was caused to patients receiving NHS-funded care.</li> <li>• <b>Incident not prevented</b> – any patient safety incident that occurred but no harm was caused to patients receiving NHS-funded care.</li> </ul>
Low harm <b>Minor (2)</b>	<p>Any patient safety incident that required extra observation or minor treatment* and caused minimal harm to one or more patients receiving NHS-funded care.</p> <p>*Minor treatment is defined as first aid, additional therapy, or additional medication. It does not include any extra stay in hospital or any extra time as an outpatient, or continued treatment over and above the treatment already planned; nor does it include a return to surgery or readmission.</p>
Moderate harm <b>Moderate (3)</b>	<p>Any patient safety incident that resulted in a moderate increase in treatment* and that caused significant but not permanent harm to one or more patients receiving NHS-funded care.</p> <p>*Moderate increase in treatment is defined as a return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another area such as intensive care as a result of the incident.</p>
Severe harm <b>Major (4)</b>	<p>Any patient safety incident that appears to have resulted in permanent harm* to one or more patients receiving NHS-funded care.</p> <p>*Permanent harm directly related to the incident and not related to the natural course of the patient’s illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiological or</p>

	<p>psychological, including removal of the wrong limb or organ, or brain damage.</p>
<p>Death <b>Catastrophic (5)</b></p>	<p>Any patient safety incident that directly resulted in the death* of one or more patients receiving NHS-funded care.</p> <p>*The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.</p>

**The Ten Principles of Duty of Candour**

<p><b>1. Acknowledgement</b></p>		<p>Acknowledge &amp; Report incident as soon as identified. Take patient and/or carer reports of incidents seriously immediately. Be compassionate and understanding.</p>
<p><b>2. Truthfulness, Timeliness, Clarity of Communication</b></p>		<p>Give information to patients and/or carers in a truthful and open manner; use an appropriately nominated person to do this. Give a step-by-step explanation considering individual needs. Be timely in delivery of information. State the facts only. Explain that new information may come to light during the investigation, and keep patients and/or carers up to date. Give clear, unambiguous information and identify single point of contact for queries. Avoid jargon.</p>
<p><b>3. Apology</b></p>		<p>Give a sincere expression of sorrow or regret to patients and/or carers, appropriately worded in an apology, as soon as possible. Give written and verbal apology. Verbal apology must not be delayed by any factors including fear, apprehension, lack of staff etc. Delays will increase patient anxiety, anger and frustration. Identify most appropriate staff member to give apology (consider seniority, relationship to patient, experience and expertise).</p>
<p><b>4. Recognising Patient and Carer Expectations</b></p>		<p>Patients and/or their carers can reasonably expect to be informed of an incident and the issues surrounding it in a face-to-face meeting with representatives from the Trust, and should be treated with sympathy, respect and consideration. Maintain confidentiality at all times. Provide support appropriate to individual needs including use of an advocate or translator. Give information re: support agencies e.g. Patient Experience Service &amp; Advocacy services.</p>
<p><b>5. Professional Support</b></p>		<p>Staff should feel supported throughout the investigation process and should not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or threat to registration. Use NPSA Incident Decision Tree to ensure consistent decision-making. If action is necessary against staff member, the Trust must preserve its position and advise staff member immediately to allow them to seek advice and/or representation. Encourage staff to seek support from professional bodies.</p>
<p><b>6. Risk Management and Systems Improvement</b></p>		

<b>7. Multidisciplinary Responsibility</b>		Use Root Cause Analysis (RCA), techniques to uncover underlying causes of the incident. Focus on improved systems of care, to be reviewed for effectiveness. Use <i>duty of candour</i> practices in conjunction with Trust incident reporting and risk management processes.
<b>8. Clinical Governance</b>		Duty of Candour applies to all Trust staff, particularly those in key roles regarding patient care. To ensure MDT approach, identify clinical, nursing and managerial opinion leaders as champions. Senior Managers and Senior Clinicians, as local opinion leaders, must participate in incident investigations and clinical risk management.
<b>9. Confidentiality</b>		Duty of Candour requires support of patient safety and quality improvement process through clinical governance frameworks to ensure lessons are learned. Accountability through the Chief Executive to the Trust Board ensures implementation of changes and effectiveness reviews. Findings should be disseminated to staff to facilitate learning. Establish practice-based systems, continuous learning programmes and audits to monitor implementation and effects of change
<b>10. Continuity of Care</b>		Give full consideration to patient confidentiality and staff privacy. Incident information should be considered confidential at all times. Consent from the individual must be sought prior to any disclosure. Where this is not possible, consent is still legal and justifiable if it is in the public interest or if those investigating the incident have statutory powers for obtaining information. Communication outside of the clinical team should be on a strictly need to know basis and records should be, where possible, anonymous. Inform the patient and/or carer who will be involved in the investigation before it takes place.
		Patients are entitled to expect they will continue to receive all usual treatment, and to be treated with respect and compassion. If the patient expresses a desire to be treated by a different team, arrangements should be made.

## GUIDANCE SUPPORTING PROCESS/REQUIREMENTS

### Special Circumstances Guidance

#### Patient Deaths

When a patient safety adverse event has resulted in a patient's death it is crucial that communication is sensitive, empathic and open. It is important to consider the emotional state of bereaved relatives or carers as well as the family's personal or religious wishes and to involve them in deciding when it is appropriate to discuss what has happened. The patient's family and/or carers will probably need information on the processes that will be followed to identify the cause(s) of death. They will also need emotional support. Establishing open channels of communication may also allow the family and/or carers to indicate if they need bereavement counselling or assistance at any stage.

Usually, the *duty of candour* discussion and any investigation will occur before a Coroner's inquest. However, in certain circumstances it may be appropriate to wait for the coroner's inquest before holding the *duty of candour* discussion with the patient's family and/or carers. The Coroner's report on post-mortem findings is a key source of information that will help to complete the picture of events leading up to the patient's death. In any event an apology should be issued as soon as possible after the patient's death, together with an explanation that the coroner's process has been initiated and a realistic timeframe of when the family and/or carers will be provided with more information. The Legal Services Manager provides a liaison role with the coroner's office and may be able to provide guidance on such details.

When a patient has died not as a consequence of the incident, Duty of Candour still applies. The Duty of Candour applies to the patient's next of kin.

#### Children

The legal age of maturity for giving consent to treatment is 16. It is the age at which a young person acquires the full rights to make decisions about their own treatment and their right to confidentiality becomes vested in them rather than their parents or guardians. However, it is still considered good practice to encourage competent children to involve their families in decision-making.

The courts have stated that younger children who understand fully what is involved in the proposed procedure can also give consent. This is sometimes known as Gillick competence or the Fraser Guidelines. Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the duty of candour process after an incident.

The opportunity for parents to be involved should still be provided unless the child expresses a wish for them not to be present.

Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents alone or in the presence of the child. In these instances the parents' views on the issue should be sought. More information can be found on the Department of Health's website: [www.dh.gov.uk](http://www.dh.gov.uk)

### **Patients with mental health difficulties**

*Duty of Candour* for Patients with mental health difficulties should follow normal procedures, unless that Patient also has cognitive impairment (see below). The only circumstances in which it is appropriate to withhold incident information from a mentally unwell Patient is when advised to do so by a Consultant Psychiatrist, who feels it would cause adverse psychological harm to the Patient. However, such circumstances are rare and a second opinion (from another Consultant Psychiatrist) would be needed to justify withholding information from the Patient. Apart from exceptional circumstances, it is never appropriate to discuss incident information with a carer or relative without express permission of the Patient; to do so is an infringement of the Patient's human rights.

### **Patients with cognitive impairment**

Some individuals have conditions that limit their ability to understand what is happening to them. They may have authorised a person to act on their behalf by an enduring power of attorney. In these cases steps must be taken to ensure this extends to decision-making and to the medical care and treatment of the Patient.

The *duty of candour* discussion would be held with the holder of the power of attorney. Where there is no such person the clinicians may act in the Patient's best interest in deciding who the appropriate person is to discuss incident information with, regarding the welfare of the Patient as a whole and not simply their medical interests. However, the Patient with a cognitive impairment should, where possible, be involved directly in communications about what has happened. An advocate with appropriate skills, such as an Independent Mental Capacity Advocate (IMCA), should be available to the Patient to assist in the communication process.

### **Patients with a learning disability**

Where a Patient has difficulties in expressing their opinion verbally, an assessment should be made about whether they are also cognitively impaired (see above). If the Patient is not cognitively impaired they should be supported in the *duty of candour process* by appropriate communication methods. An advocate, agreed on in consultation with the Patient, should be appointed. Appropriate advocates may include carers, family or friends of the Patient. The advocate should assist the Patient during the *duty of candour process*, focusing on ensuring that the Patient's views are considered and discussed.

### **Patients with a different language or cultural considerations**

The need for translation and advocacy services, and consideration of special cultural needs (such as for patients from cultures that make it difficult for a woman to talk to a male about intimate issues), must be taken into account when planning to discuss patient safety adverse 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 patient's family or friends as they may distort information by editing what is communicated.

### **Patients with different communication needs**

A number of patients will have particular communication difficulties, such as a hearing impairment. Plans for the meeting should fully consider these needs.

Knowing how to enable or enhance communications with a patient is essential to facilitating an effective *duty of candour* process, focusing on the needs of individuals and their families and being personally thoughtful and respectful.

### **Patients who do not agree with the information provided**

Sometimes, despite the best efforts of healthcare staff or others, the relationship between the patient and/or their carers and the healthcare professional breaks down. They may not accept the information provided or may not wish to participate in the *duty of candour* process. In this case the following strategies may assist:

- Deal with the issue as soon as it emerges;
- Where the patient agrees, ensure their carers are involved in discussions from the beginning;
- Ensure the patient has access to support services;
- Where the senior health professional is not aware of the relationship difficulties, provide mechanisms for communicating information, such as the patient expressing their concerns to other members of the clinical team;
- Offer the patient and/or their carers another contact person with whom they may feel more comfortable. This could be another member of the team, a senior manager of the service or Executive Director of Solent NHS Trust;
- Use a mutually acceptable mediator to help identify the issues between the healthcare organisation and the patient, and to look for a mutually agreeable solution;
- Ensure the patient and/or their carers are fully aware of the formal complaints procedures;
- Write a comprehensive list of the points that the patient and/or their carer disagree with and reassure them you will follow up these issues.

### **Multi-disciplinary responsibility**

This policy applies to all staff that hold key roles in the patient's care. Most healthcare provision involves multidisciplinary teams and communication with patients and/or their carers should reflect this following an adverse event that led to harm. This will ensure that the *duty of candour* process is consistent with the philosophy that adverse events usually result from systems failures and rarely from the actions of an individual.

## **Support and Advice for those who are Bereaved**

### **NATIONAL ORGANISATIONS**

#### **Cruse Bereavement Care**

Cruse Bereavement Care, Cruse House, PO Box 800, Richmond, Surrey, TW9 1RG Phone: 020 8939 9530 Email: [info@cruse.org.uk](mailto:info@cruse.org.uk)  
[www.crusebereavementcare.org.uk](http://www.crusebereavementcare.org.uk)

Charity providing information to anyone who has been affected by a death. Also offers education, support, information and publications to anyone supporting bereaved people. A national charity with over 6,000 trained counsellors.

#### **Supportline**

PO Box 2860, Romford, Essex, RM7 1JA  
Helpline: 01708 765200 (opening hours vary)  
[www.supportline.org.uk](http://www.supportline.org.uk)

A helpline providing confidential emotional support to children, young people and adults on any issue - referring callers to sources of help in their immediate area.

#### **British Association for Counselling and Psychotherapy**

BACP House, 15 St Johns Business Park, Lutterworth, Leicestershire LE17 4HB  
Tel: 01455 883316 [www.bacp.co.uk](http://www.bacp.co.uk)

The 'Seeking a Therapist' section of the website gives lists of qualified counsellors and psychotherapists available in your area. This service is also available over the phone.

#### **Royal College of Psychiatrists**

[www.rcpsych.ac.uk/info/help/bereav/](http://www.rcpsych.ac.uk/info/help/bereav/)

In-depth information about the emotions you may feel during bereavement.

#### **Depression Alliance**

20 Great Dover Street, London SE1 4LX  
Tel: 0845 123 2320  
[www.depressionalliance.org](http://www.depressionalliance.org)

UK charity offering information to people with depression; run by sufferers.

#### **Samaritans**

Helpline: 08457 90 90 90 (24 hours)  
[www.samaritans.org](http://www.samaritans.org)

24-hour confidential emotional support for anyone in a crisis.

### **If I Should Die**

[www.ifishoulddie.co.uk](http://www.ifishoulddie.co.uk)

This website looks at all aspects of bereavement from the practical to the emotional.

### **SUPPORT FOR CARERS**

#### **The Princess Royal Trust for Carers**

Unit 14 Bourne Court, Southend Road, Woodford Green, Essex IG8 8HD

Tel: 0844 8004361 [www.carers.org](http://www.carers.org)

Information, support and practical help for all carers through a network of Princess Royal Trust for Carers centres.

#### **Carers UK/ Carers National Association**

20-25 Glasshouse Yard, London EC1A 4JS

Helpline: 0808 808 7777 (free phone, 10am-12noon and 2pm-4pm, Mon-Fri)

[www.carersuk.org.uk/about/main.htm](http://www.carersuk.org.uk/about/main.htm)

Runs a helpline and provides support, encouraging carers to recognise their own needs. There is also an information officer to answer enquiries from professionals.

#### **Caring Matters**

132 Gloucester Place, London NW1 6DT

Tel: 020 7402 270

Focuses on the rights and responsibilities of everyone receiving or providing long-term care services.

#### **Seniorline**

207/221 Pentonville Road, London N1 9UZ

England, Scotland, Wales: 0808 800 6565 (freephone)

Northern Ireland: 0808 808 7575 (freephone)

The lines are open Mon-Fri between 9am-4pm.

Free national information service for senior citizens, their carers and relatives.

### **WHEN A BABY OR CHILD DIES**

#### **Child Death Helpline**

York House, 37 Queen Square, London WC1N 3BH

Tel: 0800 282 986

[www.childdeathhelpline.org.uk](http://www.childdeathhelpline.org.uk)

A telephone helpline which offers help and support to anyone affected by the death of a child. Staffed by parent volunteers who are supported by a professional team.

#### **Compassionate Friends**

53 North Street, Bedminster, Bristol BS3 1EN

Help Line: 0845 123 2304 (seven days 9.30am-10.30pm)

[www.tcf.org.uk](http://www.tcf.org.uk)

Support and friendship for bereaved parents and their families.

**SANDS - Stillbirth and Neonatal Death Society (UK)**

28 Portland Place, London W1N 4DE

Helpline: 0207 436 5881

[www.uk-sands.org](http://www.uk-sands.org)

A national self-help organisation that provides support for bereaved parents and their families whose baby has died at or soon after birth.

**The Cot Death Society**

10 High Street, Thatcham, Berkshire RG19 3JD

Tel: 01635 861 771

Help and support for anyone affected by cot death.

Scottish Cot Death Trust

Tel: 0141 357 3946

[www.sidscotland.org.uk](http://www.sidscotland.org.uk)

Provides support and information to parents bereaved by sudden infant deaths.

**The Foundation for the Study of Infant Deaths**

PO Box 1168, Southampton, SO15 8XZ

24-hour helpline: 0207 235 1721

Offers help to those who have lost a baby.

[www.babyloss.com](http://www.babyloss.com)

An exclusively online resource for anyone whose life has been touched by pregnancy loss, stillbirth or neonatal death.

**LOSS IN PREGNANCY****Miscarriage Association:**

c/o Clayton Hospital, Northgate, Wakefield, West Yorkshire WF1 3JS

Helpline: 01924 200 799

Helpline (Scotland): 0131 331 883

[www.miscarriageassociation.org.uk](http://www.miscarriageassociation.org.uk)

Provides support for those who have suffered the loss of a baby during pregnancy.

**HELP FOR YOUNG PEOPLE****The Child Bereavement Trust**

The Saunderton Estate, Wycombe Road, Saunderton, Bucks HP14 4BF

Information and support service line: 01495 568900

[enquiries@childbereavement.org.uk](mailto:enquiries@childbereavement.org.uk)

[www.childbereavement.org.uk](http://www.childbereavement.org.uk)

National UK charity providing specialised training and support for professionals to help them respond to the needs of bereaved families. Resources and information for bereaved children and families as well as the doctors, nurses, midwives, teachers, police, emergency services and voluntary sector support services.

**rd4u**

Cruse Bereavement Care, Cruse House, 126 Sheen Road, Richmond, Surrey, TW9 1UR

Helpline: 0808 808 1677 (answered by trained volunteers aged between 16-25, 4pm-7pm, Mon-Wed)

[www.rd4u.org.uk](http://www.rd4u.org.uk)

The youth branch of Cruse, set up to help young people after the death of someone close.

#### **Winston's Wish**

4th Floor, St James House, St James Square, Cheltenham GL50 3PR

Helpline: 0845 2030405 (9.30am-5pm, Mon-Fri; 9.30am-1pm, Sat)

[www.winstonswish.org.uk](http://www.winstonswish.org.uk)

Charity that offers support to young people who have experienced bereavement.

#### **ChildLine**

Helpline: 0800 1111

[www.ChildLine.org.uk](http://www.ChildLine.org.uk)

Free, 24-hour helpline for children and young people who need to talk about any problem they may have.

#### **Childhood Bereavement Network**

8 Wakley Street, London EC1V 7QE

Tel: 020 7843 6309

[www.childhoodbereavementnetwork.org.uk](http://www.childhoodbereavementnetwork.org.uk)

A new national resource for bereaved children and young people, their parents and care

#### **Support for patients or relatives in making a complaint against an NHS organisation**

Independent Complaints Advocacy Service (ICAS)

1st floor, Clarendon House, 9-11 Church Street, Basingstoke, RG21 7QG

Tel: 01256 463758

#### **Mental Capacity Advocacy:**

##### **Which IMCA service to use**

The IMCA Service that a service user is referred to is based on the location of the user at the time they need the service. For example, this would be the location of the hospital where the person is an inpatient, even though this is temporary and could be different from where they live. So e.g. inpatients at St Marys Hospital, Portsmouth will need to be referred to the Portsmouth IMCA service.

#### **Hampshire Mental Capacity Advocates:**

17 New Road, Basingstoke RG21 7PR, Tel: 01256 478999

Email: [imca@hampshireadvocacy.org.uk](mailto:imca@hampshireadvocacy.org.uk).

Website: [www.hampshireadvocacy.org.uk](http://www.hampshireadvocacy.org.uk)

**Portsmouth Mental Capacity Advocates**

South of England Advocacy Projects email: [Jill.miles@seap.org.uk](mailto:Jill.miles@seap.org.uk)

**Southampton**

Choices Advocacy website: [www.choices-advocacy.org.uk](http://www.choices-advocacy.org.uk)

**APPENDIX 4**

**Approved Process for Communication**

<b>Standard</b>	<b>Process for monitoring compliance</b>	<b>Evidence required to support compliance</b>	<b>Frequency</b>	<b>Responsibility of</b>	<b>Designated Committee</b>
<p><b>Standard 5 – Criterion 10 Being Open</b>                      The organisation has an approved documented process for ensuring that all communication is open, honest and occurs as soon as possible following an incident, complaint or claim that is implemented and monitored.</p>					
<b>Process for encouraging open communication</b>	10% of applicable Serious Incidents Requiring Investigation (SIRI), and Adverse Events will be reviewed by considering paperwork detailing the application of Being Open.	Reports and minutes	Annual	Legal Services Manager	Quality Improvement and Risk Group
<b>Process for acknowledging, apologising and explaining when things go wrong</b>	10% of applicable Serious Incidents Requiring Investigation (SIRI), and Adverse Events will be reviewed by considering paperwork detailing the application of Being Open.				
<b>Requirements for truthfulness, timeliness and clarity of communication</b>	10% of applicable Serious Incidents Requiring Investigation (SIRI), and Adverse Events will be reviewed by considering paperwork detailing the application of Being Open.	Reports and minutes	Annual	Legal and Services Manager	Quality Improvement and Risk Group
<b>Provision of additional support as required</b>	10% of applicable Serious Incidents Requiring Investigation (SIRI), and Adverse Events will be reviewed by considering paperwork	Reports and minutes	Annual	Legal and Services Manager	Quality Improvement and Risk Group

	detailing the application of Being Open.				
<b>Requirements for documenting all communication</b>	10% of applicable Serious Incidents Requiring Investigation (SIRI), and Adverse Events will be reviewed by considering paperwork detailing the application of Being Open.	Reports and minutes	Annual	Legal and Services Manager.	Quality Improvement and Risk Group

## Equality Impact Assessment

<b>Step 1 – Scoping; identify the policies aims</b>		<b>Answer</b>	
1. What are the main aims and objectives of the document?	To detail Solent NHS Trust's approach to Duty of Candour following a patient safety incident, complaint or claim and to detail the process.		
2. Who will be affected by it?	Staff delivering and patients / patient's relatives or carers receiving communication.		
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	Duty of Candour is closely linked to subsequent complaints or claims. We aim to improve the handling of communications for the benefit of patients (or patient's relatives and carers) and staff leading to less complaints and claims raised through dissatisfaction.		
4. What information do you already have on the equality impact of this document?	None		
5. Are there demographic changes or trends locally to be considered?	No		
6. What other information do you need?	None		
<b>Step 2 - Assessing the Impact; consider the data and research</b>	<b>Yes</b>	<b>No</b>	<b>Answer (Evidence)</b>
1. Could the document unlawfully against any group?		X	
2. Can any group benefit or be excluded?		X	All inclusive policy
3. Can any group be denied fair & equal access to or treatment as a result of this document?		X	
4. Can this actively promote good relations with and between different groups?	X		
5. Have you carried out any consultation internally/externally with relevant individual groups?		X	
6. Have you used a variety of different methods of consultation/involvement		X	
Mental Capacity Act implications			
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)		X	Where there is an issue of capacity, the DoLS & MCA Policy will be referred to.

If there is no negative impact – end the Impact Assessment here.

(Contact address and telephone number)

**Private and Confidential**

*(Insert Date)*

**Letter to be sent to the patient affected by the incident**

*(remove priory to sending)*

Dear (name of patient)

You were recently receiving care at **(Site)** Solent NHS TRUST and as the Dr/Nurse **(Name and Designation)** explained to you **(brief description of the incident and what has previously been discussed)**

I would like to take this opportunity to express my sincere apologies that this event has occurred while you were under our care and to assure you that the TRUST aims to provide a quality service to all our patients. We are therefore, undertaking a full investigation into the incident in an effort to understand exactly what happened and to find out whether there is something that we could do differently in future to prevent this happening to anyone else.

We would like the opportunity to discuss and share our findings with you and therefore, I would like to invite you to come to a meeting once the investigation has been completed, which can be arranged at a mutually convenient time. Alternatively it may be that you do not feel a meeting would be of any help, either now or in the future, we just wanted to give you the opportunity should you wish to do so.

The investigation process can take up to 60 working days to complete. At this stage **(I/ Staff member contact details on top of page)** will be acting as your lead contact for the duration of this process.

Yours sincerely

**Private and Confidential**

*(Insert Date)*

**Letter to be sent to relatives where patient does not have capacity**  
*(remove priory to sending)*

Dear (name)

Your **[Mother/Father/Son etc]** was recently receiving care at **(Site)** Solent NHS TRUST and as the Dr/Nurse **(Name and Designation)** explained to you **(brief description of the incident and what has previously been discussed)** whilst your **[Mother/Father/Son etc]** was a patient on **(Site)**.

I would like to take this opportunity to express my sincere apologies that this event has occurred while **(name of patient)** were under our care and to assure you that the TRUST aims to provide a quality service to all our patients. We are therefore, undertaking a full investigation into the incident in an effort to understand exactly what happened and to find out whether there is something that we could do differently in future to prevent this happening to anyone else.

We would like the opportunity to discuss and share our findings with you and therefore, I would like to invite you to come to a meeting once the investigation has been completed, which can be arranged at a mutually convenient time. Alternatively it may be that you do not feel a meeting would be of any help, either now or in the future, we just wanted to give you the opportunity should you wish to do so.

The investigation process can take up to 60 working days to complete. At this stage **(I/ Staff member contact details on top of page)** will be acting as your lead contact for the duration of this process.

Yours sincerely

(Contact address and telephone number)

**Private and Confidential**

*(Insert Date)*

**Letter to be sent to relatives where the patient has died**

*(Remove prior to sending)*

Dear (name)

I am writing to offer you my sincere condolences on the recent death of your  
*[Mother/Father/Son] [name of patient]*.

*[Name of patient]* was recently receiving care at **(Site)** Solent NHS TRUST and as the Dr/Nurse  
**(Name and Designation)** explained to you **(brief description of the incident and what has  
previously been discussed)**

I would like to take this opportunity to express my sincere apologies that this event has occurred while **[name of patient]** were under our care and to assure you that the TRUST aims to provide a quality service to all our patients. We are therefore, undertaking a full investigation into the incident in an effort to understand exactly what happened and to find out whether there is something that we could do differently in future to prevent this happening to anyone else.

We would like the opportunity to discuss and share our findings with you and therefore, I would like to invite you to come to a meeting once the investigation has been completed, which can be arranged at a mutually convenient time. Alternatively it may be that you do not feel a meeting would be of any help, either now or in the future, we just wanted to give you the opportunity should you wish to do so.

The investigation process can take up to 60 working days to complete. At this stage **(I/ Staff member contact details on top of page)** will be acting as your lead contact for the duration of this process.

Yours sincerely