



BEING OPEN AND DUTY OF CANDOUR POLICY AND PROCEDURE

Approved by:	Board of Trustees
Date of approval:	May 2025
Originator:	Chief Executive
Review date:	May 2028

Ultimate Responsibility: Chief Executive/Board of Trustees

Responsibility/Accountability : The Director of Clinical Services is responsible for ensuring the effective implementation of this policy and procedure.

First Line Responsibility: All Staff involved are responsible for ensuring compliance with the policy.

Related Policies and Procedures

- 1.4.1 Wellbeing Space Operational Policy
- 1.4.2 Hospice at Home Operational Policy and Procedure
- 1.4.3 Bereavement Service Operational Policy and Procedure
- 1.4.4 Complementary Therapy Operational Policy and Procedure
- 1.4.6 Support and Information Service Operational Policy and Procedure
- 3.1.2 Complaints Policy and Procedure
- 3.1.5 Data Protection and Confidentiality Policy
- 3.1.12 Risk Management Policy
- 3.1.13 Safeguarding Children Policy and Procedure
- 3.1.14 Safeguarding Vulnerable Adults Policy and procedure
- 4.1.6 Whistle blowing policy and procedure
- 6.1.4 Accident and Untoward Incident Procedure
- 7.1.1 Assessment, Treatment and Care Procedure
- 7.1.2 Consent Mental Capacity and Advanced Directive Policy and Procedure
- 7.1.32 Quality of Treatment and Care Policy and Monitoring Procedure
- 7.1.7 JH May 2025

7.1.38 Patient Access to Health Records Policy and Procedure

Policy Monitoring and Review

The policy will be reviewed as a minimum every three years or sooner if legislation requires

Compliance with Statutory Requirements

Regulation 20: Duty of candour

Regulation 5: Fit and proper persons: directors

[Regulation 12: Safe care and treatment](#)

[Regulation 16: Receiving and acting on complaints](#)

[Regulation 19: Fit and proper persons employed](#)

Public Interest Disclosure Act 1998

Policy Statement

Treetops Hospice is committed to the provision of high-quality care in a culture of openness and transparency for all people that access our clinical services.

We do acknowledge that care and treatment is not harm free and mistakes do happen. If an error does occur, patients and their families will be offered an apology, truthful information and support. Learning from incidents will contribute to a culture of safety and improvement to prevent a similar incident happening to someone else.

Clinicians already have an ethical duty of candour as part of their professional registration to tell patients about errors and mistakes. This policy builds on individual professional duty and places an obligation on the organisation, to be open with patients when harm has been caused.

The impact and consequences of mistakes or errors can affect everyone involved and can be devastating for individual staff or teams; this policy aims to ensure there is sustained support for staff in reporting incidents and in being open.

This approach underpins a commitment to provide high quality care and truthful sharing of information when an incident of patient harm occurs both at an organisational as well as an individual level and that any learning will be embedded into daily practice. The organisational values and clinical leadership aim to ensure a culture of candour by every member of staff and a continued commitment to patient safety.

Scope

Candour is defined in The Francis report as:-

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

made.”

The statutory Duty of Candour only applies to incidents where a patient suffered (or could have suffered) unintended harm resulting in moderate or severe harm or death or prolonged psychological harm.

The requirements of the **Duty of Candour** as set out by the regulations are as follows:-

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

- (a) notify the relevant person that the incident has occurred
- (b) provide reasonable support to the relevant person in relation to the incident, including when giving such notification

The notification to be given must:

- (a) be given in person by one or more representatives of the organisation,
- (b) provide an account, which to the best of the organisations knowledge is true, of all the facts about the incident,
- (c) advise the relevant person what further enquiries into the incident are believed to be appropriate,
- (d) include an apology, and be recorded in a written record which is kept securely
- (e) The notification must be followed up in writing.

Incidents that result in no harm or low harm are not covered by the Duty of Candour. Patients should still be informed of such events in line with being open, but the emphasis for the Duty of Candour is on incidents that result in moderate harm, severe harm or death.

Staff Responsibilities

The Chief Executive is responsible for ensuring that this policy is adhered to.

All staff are responsible for ensuring compliance with the policy.

Staff Training Requirements

All new clinical staff will receive training on Being Open and Duty of Candour as part of the their induction Programme. This will be periodically updated as part of specific Continuing Professional Development (CPD) training.

Dissemination and Implementation

This policy and its associated procedural document will be available on the organisation's intranet. It will be disseminated and implemented by departmental line managers

Procedure

Introduction to Being Open and Duty of Candour

All staff must understand their duty for being open and must demonstrate the principles of being open in their work.

It is recognised however that many scenarios do not always follow predetermined processes, and staff must use their own professional judgement/seek further advice in deciding, for example, when is the right time to talk to patients and families/carers.

Incident Identification and Reporting

Firstly any actions that can be taken immediately to reduce the risk of harm to the patient or other patients must be implemented.

The initial facts of the incident should be established and an assessment of the level of harm that has happened to the patient as a result of the incident (see table below) should be undertaken.

Incident	Action
No harm <i>(including prevented patient safety incidents)</i>	<ul style="list-style-type: none">○ Patients are not usually contacted or involved in investigations and these types of incidents are <u>outside</u> the scope of the <i>Duty of Candour</i>. Openness remains best practice, but there is no requirement to follow the Duty of Candour processes.

<p>Low harm</p>	<ul style="list-style-type: none"> ○ Unless there are specific indications or the patient requests it, the communication, investigation and analysis, and the implementation of changes will occur with those directly involved in the incident. ○ Communication should take the form of an open discussion between the staff providing the patient's care and the patient and/or their carers'. ○ Reporting to the operational managers will occur through incident reporting and will be analysed centrally to detect high frequency events. ○ Review will occur through collated trend data and local investigation. Where the trend data indicates a pattern of related events, further investigation and analysis may be needed. <p>Openness remains best practice, but there is no requirement to follow the Duty of Candour processes for incidents that result in this level of harm. .</p>
<p>Moderate harm</p> <p>Severe harm or death</p> <p>(For definition of harm see Appendix 2)</p>	<ul style="list-style-type: none"> ○ <u>The <i>Duty of Candour</i> procedure is implemented.</u> ○ It will be necessary to inform the Director of Clinical Services and appropriate Operational Managers immediately to ensure everyone who needs to know is informed. Senior Leadership Team members will be informed of the incident and the management plans as a priority. ○ The NHS Derby and Derbyshire Integrated Care Board and regulators, will be informed of the incident and the management plans as a priority. ○ The incident report must be completed as soon as possible after the incident has been discovered

Principles of Communication and Being Open

There are a set of 10 principles for *Being Open*, National Patient Safety Agency 2009, (Appendix 1) that staff should refer to when communicating with the relevant person following an incident in which the patient/service user was harmed.

Mental Capacity

Where the patient or service user is assessed as not having the capacity to make a decision in relation to their care or treatment, or where the patient/service user is deemed not to have the necessary competency, then the most appropriate relevant person should be notified of the incident.

Confidentiality

Details of a patient's care and treatment should at all times be considered confidential. Where the Duty of Candour would include providing confidential information to family or carers, then the consent of the individual concerned should be sought prior to disclosing information. This consent or denial of consent to share should be recorded in the patient record.

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

Initial communication with the relevant person and offering an apology

The initial 'being open' communications will vary according to the individual needs of the relevant person, the severity grading of the incident, clinical outcome and family circumstances for each specific event. The most senior clinician on the clinical shift should coordinate this initial communication, ensuring that the relevant person receives clear, unambiguous explanation of the event, and the next steps to be taken. It is also vital that staff involved in the incident receive appropriate support from the outset.

In the event a patient safety incident is identified in retrospect and/or relates to patients that are deceased the principles of Duty of Candour still apply. The nominated family member or significant other should be informed of the incident and potential pending investigation. All decision making must be recorded in the patient record.

The Relevant Person cannot be contacted or declines to have further information

If, after discussion, the patient says they do not want more information, then the possible consequences must be explained to them. It should be made clear that they can change their mind and have more information at any time.

All Duty of Candour conversations must be recorded in the patient record including instances when the patient has declined the offer of further information.

Where a relevant person cannot be contacted, a clear written record must be kept of the attempts made to contact or speak to the relevant person. This should evidence that every reasonable effort was made to contact the person by stating how many attempts were made, who by and when.

Apology

Where a patient safety incident has caused harm, an apology must be offered to the relevant person – a sincere expression of sorrow or regret for any possible harm and distress caused.

Guidance from the NHS Litigation Authority (2009) states:

"It is both natural and desirable for clinicians who have provided treatment which

produces an adverse result, for whatever reason, to sympathise with the patient or the patient's relatives; to express sorrow or regret at the outcome; and to apologise for shortcomings in treatment. It is most important to patients that they or their relatives receive a meaningful apology. We encourage this, and stress that apologies do not constitute an admission of liability. In addition, it is not our policy to dispute any payment, under any scheme, solely on the grounds of such an apology."

Clarity of Communication

The individual communication needs of the relevant person, for example, linguistic or cultural needs, learning disabilities, or sensory impairments must be considered and taken into full account before any discussion takes place. This involves consideration of circumstances that can include a patient requiring additional support, such as an independent patient advisor or a translator.

Initial meeting with the relevant person

The relevant person should be initially informed of the issues surrounding the patient safety incident and its consequences in a face to face meeting.

The facts that are known should be explained. When talking to the relevant person about the incident staff must use clear, straightforward language and be honest with responses to any questions that are raised.

The relevant person should be informed that an incident analysis will be carried out and more information will become available as this progresses.

It should be made clear to the relevant person that new facts may emerge as the incident analysis proceeds.

The relevant person's understanding of what happened should be established from the outset, as well as any questions they may have.

There should be consideration and formal noting of the relevant person's views and concerns, and demonstration that these have been heard and taken seriously.

An explanation should be given about what will happen next in terms of the long-term treatment plan for the patient as well as the incident analysis findings.

Information on likely short and long-term effects of the incident (if known) should be shared.

An offer of practical and emotional support should be made to the relevant person.

Patients, family and/or carers might be anxious, angry and frustrated, even when the discussion is conducted appropriately. It is essential that staff are not drawn into speculation, attribution of blame, denial of responsibility or the provision of conflicting information.

The Investigation

For Serious Incidents, the Investigating Officer (IO) will undertake a Root Cause Analysis (RCA). This will be undertaken within 28 days of the incident being reported.

The IO will meet with the employee(s) directly involved in the incident to establish the facts.

Where an incident is notifiable but does not meet the criteria for a Serious Incident, then this will be classed as a 'Significant Event' and an RCA must be undertaken.

The actions above should be followed by a letter to the patient/relatives with an offer of a meeting, if this is appropriate. This should be written by the most appropriate person. This may be before the conclusion of the investigation. An example template letter is provided in Appendix 3.

The letter should advise the patient of the independent advocacy service available to support and assist them.

The Investigating Officer will keep the Director of Clinical Services up to date on progress with the investigation.

The Notification Meeting

A meeting with the relevant person should be arranged as soon as possible after the incident has happened to notify them of the incident. This meeting should always take place within 10 working days of the incident being discovered.

Staff identified to lead this meeting 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

It may be appropriate for more than one member of staff to meet with the relevant person for support or for additional information.

At the meeting the nominated member of staff should follow the procedure below:-

- If known, explain what went wrong and where possible, why it went wrong;
- Inform the patient and/or relative(s) and others what steps are being/will be

- taken to prevent the incident recurring;
- Offer an apology;
- Provide opportunity for the patient and/or relatives and others to ask any questions;
- Agree with the patient and/or relatives and others any future meetings as appropriate;
- Suggest any sources of additional support and counselling and provide written information if appropriate.
- Inform the relevant person that they will receive a written summary of the incident and that they will be, if they wish, be informed of progress with the investigation. The relevant person will also receive a copy of the final investigation report.

Wherever possible a named contact should be provided who the relevant person can speak to regarding the incident. This can be a manager in the clinical team or another member of staff who has the skills and knowledge to undertake this role. It is vitally important that whoever is named as the contact is made aware of this, agrees to the role and is furnished with all of the information they may need to ensure clear and honest communication takes place.

The senior manager/clinician for the service should be informed of the outcome of any meeting.

The communication and outcome of the notification must be clearly recorded in the clinical notes by the person who has informed the patient/family

A letter should then be written to the relevant person setting out what was explained at the notification meeting. The letter should be drafted immediately after the notification meeting and forwarded to the Director of Clinical Services for approval prior to sending out. The letter must contain all the information that was provided at the initial notification meeting.

Any Duty of Candour letters arising out of the notification meeting must be signed off by the Director of Clinical Services and a copy kept in the clinical notes.

If, for whatever reason, the patient cannot be contacted in person or declines to speak to anyone from the organisation in relation to the incident, then the above processes do not apply but a written record must be kept of the attempts made to contact or to speak to the relevant person.

Investigation Closure and Learning

The full RCA report will be presented to the Clinical Sub Committee. This will include details of how the Duty of Candour has been implemented.

Once the incident is signed off for closure by the Clinical Sub Committee, a letter should be sent to the relevant person together with the anonymised investigation report and action plan. The supporting letter should provide information in the event

that the individual wishes to pursue legal action against the organisation. This letter will be signed off by the Chief Executive Officer or their nominated deputy.

If the RCA is not available within the usual time frame for closure, a letter should be sent to the relevant person to provide an explanation as to when they can expect to be provided with additional details. This letter should clarify the information previously provided; reiterate key points, and record action points and future deadlines. This letter should also provide information in the event that the individual wishes to pursue legal action against the Trust.

All learning from the incidents must be cascaded via the Clinical Sub Committee, Health and Safety Committee and Team Meetings. This information will be relayed to Trust Board through the Director of Clinical Services report.

The outcome of reports must also be shared with any other healthcare organisation or relevant stakeholder as appropriate to optimise learning from the incident.

Record keeping

All correspondence should be held in accordance with Records Management Policy.

With specific relation to the Being Open/Duty of Candour the clinical records must:

- Record the sharing of any facts that are known and agreed with the relevant person;
Record how it has been agreed that the relevant person will be kept informed of the progress and results of that investigation;
- Record, where appropriate, a full apology to the patient and their family/carers;
- Record any explanation given of the likely short and long-term effects of the incident;
- Contain copies of any letters sent to the relevant person;
- Record an offer of appropriate practical and emotional support.

Performance/Disciplinary Issues

As previously described, the organisation will strive to identify the underlying causes of patient safety incidents (i.e. systems failures or latent conditions) through RCA processes.

Any identified disciplinary issues will be dealt with according to the staff disciplinary policy.

The potential implications of not implementing the Duty of Candour requirements

Support and Advice for Staff

It is very rare for staff in healthcare to go to work with the intention of causing harm or failing to do the right thing. While we do all we can to minimise risks, it will never be possible to eliminate them fully. It should be acknowledged from the outset that many 'human factors' can increase the risk of incidents occurring such as:

- Workload
- Distractions
- Physical environment
- Physical demands
- Device/product design.

It is uncommon for any single action or 'failure' to be wholly responsible. The focus following an incident should always be on learning and prevention rather than individual blame.

Involvement in an incident and particularly a serious incident can have profound consequences on staff members who may experience a range of reactions. The high personal and professional standards of most clinicians and other staff may make them particularly vulnerable to these experiences. Different individuals will have differing responses to the same incident and support should always therefore be tailored to the individual.

Appendix 1

The 10 Principles of Being Open - *Being open* involves apologising when something has gone wrong, being open about what has happened, how and why it may have happened, and keeping the patient and their family informed as part of any subsequent review.

1. Principle of Acknowledgement

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

2. Principles of Truthfulness, Timeliness and Clarity of Communication

Information about a patient safety incident must be given in a truthful and open manner by an appropriately nominated person. Communication should be timely, informing the patient, their family and carers what has happened as soon as is

practicable, based solely on the facts known at that time. It will be explained that new information may emerge as the event investigation takes place. Patients, their families and carers and appointed advocates should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have.

3. Principle of an Apology

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

4. Principle of Recognising Patient and Carer Expectations

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

5. Principle of Professional Support

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

6. Principle of Risk Management and Systems Improvement

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

7. Principles of Multi-Disciplinary Responsibility

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

8. Principles of Clinical Governance

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

9. Principle of Confidentiality

Details of a patient safety incidents should at all times be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the patient.

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

10. Principle of Continuity of Care

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

National Patient Safety Agency 2005

Appendix 2

Definitions of harm

Moderate harm - 'Moderate harm' means harm that requires a moderate increase in treatment, and significant, but not permanent, harm, for example a "moderate increase in treatment" means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care).

Prolonged pain 'Prolonged pain' means pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;

Prolonged psychological harm 'Prolonged psychological harm' means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

Severe harm - 'Severe harm' means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.

Appendix 3

Guidance Letter Template for Initial Notification Communication Letter in Accordance with Requirements of Duty of Candour.

NB This is provided purely for guidance. All letters must be personalised and tailored to the individual needs of the person receiving the letter.

Dear Mrs/Mrs xxxxxxxxxxxx

I am writing to express my sincere regret that (you/your relative XXXXX) has been involved in an incident whereby(describe event here). As an organisation we are committed to being open with patients and carers when events such as these occur so that we gain a shared understanding of what happened, and what we can do to prevent such an incident occurring again in the future.

An investigation is already underway to try and establish the cause of the incident. If

you would like to meet with a member of staff to discuss this, please let me know within the next two weeks, and we will arrange a mutually convenient time and place to meet.

There is an independent advocacy service available to support and assist you in this who can be contacted on XXXXXXXX.

Staff member XXXXX is acting as your lead contact for the duration of the investigation. They can be contacted by email on xxxxxxxxxxxxxxxx or on telephone number xxxxx xxxxxxxx

Yours sincerely

Signed..... Trustee

Date.....

