DUTY OF CANDOUR AND BEING OPEN POLICY

Version: 8
Issue Date: 25 September 2019
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Document Manager (job title): Head of Risk Management
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Related Procedural Documents:
- Safety Learning Event and Near Misses Policy
- Serious Incidents Requiring Investigation Policy
- Complaints, Comments, Concerns and Plaudits Policy
- Claims Management Policy

Key Words (to aid with searching):
- Incident, Serious Incident Requiring Investigation, Safety Learning Event (SLE), Complaint, Claim

Version Tracking

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<th>Version</th>
<th>Date Ratified</th>
<th>Brief Summary of Changes</th>
<th>Author</th>
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<tr>
<td>8</td>
<td>24 Sept 2019</td>
<td>• Update process&lt;br&gt;• New concise policy format.</td>
<td>Head of Risk Management</td>
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<td>• Remove reference to Adverse Incident and replace with Safety Learning Event.&lt;br&gt;• Revise process in line with SIRI process (Updated Jul 16)&lt;br&gt;• Update to recording compliance on Datix&lt;br&gt;• Update Responsibilities&lt;br&gt;• Update letter templates.</td>
<td>Head of Risk Management</td>
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<td>• Re-title to add Duty of Candour&lt;br&gt;• Include Duty of Candour legislation requirements/flow chart and letter templates</td>
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<td>• Version tracking included&lt;br&gt;• Update to responsibilities&lt;br&gt;• Inclusion of Duty of Candour Requirements&lt;br&gt;• Being open discussion guidance</td>
<td>Risk Coordinator</td>
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1. INTRODUCTION

Portsmouth Hospitals NHS Trust (the Trust) recognises the importance promoting a culture of being open and transparent with people who use services and other ‘relevant persons’ in relation to care and treatment.

This policy sets out the requirements that must be followed when things go wrong with care and treatment; including informing people about the incident, providing reasonable support, truthful information and an apology when things go wrong.

THE PROFESSIONAL DUTY OF CANDOUR

Every healthcare professional must be open and honest with patients, or where appropriate the patient’s advocate, carer or family, when something goes wrong with their treatment or care or which causes, or has the potential to cause, harm or distress. This means that healthcare professionals must:

- tell the patient when something has gone wrong
- apologise to the patient offer an appropriate remedy or support to put matters right (if possible)
- explain fully to the patient the short and long term effects of what has happened (taking into account information available at the time which could alter following investigation)

Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must also be open and honest with their regulators, raising concerns where appropriate.

They must support and encourage each other to be open and honest, and not stop someone from raising concerns.

It is a legal requirement to comply with the requirements of the Duty of Candour process where this is applicable.

Remember: saying sorry is not an admission of liability and is the right thing to do.

Being Open

Patients, families and carers have a right to expect that concerns and complaints can be raised freely without fear and any questions asked to be answered with honesty and openness from the services that they receive care from.

The principles of Being Open apply to all events where harm has occurred during the provision of health care. This can be as a result of an adverse incident, a complaint or a claim when communication with patients, their families and carers is essential.

2. PROCESS

The Being Open/Duty of Candour process begins when a notifiable safety incident has occurred (incidents that, in the reasonable opinion of a healthcare professional, could result in, or appear to have resulted in, the death of the person using the service or severe harm, moderate harm, or prolonged psychological harm). Where the degree of harm is not yet clear but may fall into the above categories in future, the relevant person must be informed of the notifiable safety incident.

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1 Where patient is referred to within this policy, consideration must be given to the patient’s advocate, carer or family

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As soon as an event is detected the top priorities are prompt and appropriate clinical care, and prevention of further harm.

If the event is considered a notifiable safety incident then it will be subject to specific Duty of Candour requirements (Appendix A). The patient, must be informed as soon as reasonably practicable after the incident has been identified; within 10 working days.
Event occurs that requires communication in line with Being Open

Safety Learning Event (SLE) confirmed as moderate/severe harm or death event.

Duty of Candour steps:
As soon as possible, within 10 days at the very latest, an open and honest verbal or face to face discussion must be held with the patient or their representative, to disclose the incident and share any facts known at that time.

This conversation must include a genuine and sincere apology for the occurrence and must be made by the lead clinician responsible for the care.

The discussion must be followed up by a written letter to the patient/ representative.

It should detail what was said, what will happen next and inviting the patient/representative to contribute to the terms of reference for the investigation, if applicable.

The conversation must be recorded in the patient’s records and letter attached to the SLE on Datix.

Relevant level of investigation undertaken according to SI Process

When investigation has been ‘signed off’ as closed by the Trust, the appropriate Division must offer a copy of the final investigation report to the patient/ representative within 10 working days, ideally at a meeting with the patient/relatives or carer.

Near miss, no/low harm SLEs, complaints and claims

Initial Being Open discussion with patient, family or carer to include apology for any harm suffered and any shortcomings in the delivery of care that led to the patient SLE or complaint.

Decide what actions are required and if follow up discussions are needed

Undertake agreed actions and ensure the following is completed on Datix:
- The chronology of clinical events and other relevant facts
- Details of the patient’s and/or their family/carer concerns
- A summary of the factors that contributed to the incident
- Information on what has been and will be done to avoid recurrence of the incident and how these improvements will be monitored
- Any lessons learnt
- Any required follow up care and how / where / by whom this will be provided
- Carry out follow up discussion with patient, family or carer where required.

Ensure appropriate feedback is given to relevant staff

All documentation relating to Duty of Candour and Being Open discussions/written communications is required to be attached to the relevant SLE or Complaint on Datix.
3. SCOPE
This policy applies to all permanent, locum, agency, bank and voluntary staff of the Trust, the MDHU (Portsmouth) and Engie, whilst acknowledging that for staff other than those directly employed by the Trust the appropriate line management or chain of command will be taken into account.

The policy outlines how the Trust will be open with patients, families and carers, implementation does not replace the personal responsibilities of staff with regard to issues of professional accountability for governance.

‘In the event of an infection outbreak, flu pandemic or major incident, the Trust recognises that it may not be possible to adhere to all aspects of this document. In such circumstances, staff should take advice from their manager and all possible action must be taken to maintain ongoing patient and staff safety’

4. TRAINING REQUIREMENTS
The principles and concept of Duty of Candour and Being Open are included in training provided on risk management/SLE reporting and complaints management.

Training is also available through the NPSA website which provides e-learning packages and video-based workshops, which are available via their website (www.npsa.nhs.uk).

Ad-hoc advice and training can be sought from the Patient Safety team.

5. REFERENCES AND ASSOCIATED DOCUMENTATION
External
• National Patient Safety Agency, 2004 Seven Steps to Patient Safety
• National Patient Safety Agency, Building a Memory: preventing harm, reducing risks and improving patient safety www.npsa.nhs.uk
• CQC Regulations Guidance (20) for NHS Bodies March 2015 www.cqc.org.uk

Internal
• Policy for the Management of Serious Incidents Requiring Investigation
• Policy for the Reporting of Adverse Incidents and Near Misses
• Policy for the Management of Complaints, Concerns, Comments and Plaudits
• Policy for the Management of Claims Clinical Negligence Liabilities to Third Parties and Property Expenses Scheme

6. EQUALITY IMPACT ASSESSMENT
Portsmouth Hospitals NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy has been assessed accordingly.

Our values are the core of what Portsmouth Hospitals NHS Trust is and what we cherish. They are beliefs that manifest in the behaviours our employees display in the workplace.
Our Values were developed after listening to our staff. They bring the Trust closer to its vision to be the best hospital, providing the best care by the best people and ensure that our patients are at the centre of all we do.

We are committed to promoting a culture founded on these values which form the 'heart' of our Trust:

- **Respect and dignity**
- **Quality of care**
- **Working together**
- **Efficiency**

This policy should be read and implemented with the Trust Values in mind at all times.

### 7. MONITORING COMPLIANCE

Being Open is a general concept and the specific delivery of ‘Being Open’ communications will vary according to the severity grading, clinical outcome and family arrangements for each specific event. In exceptional cases information may need to be withheld or specific legal requirements might preclude disclosure. Equally records of communications with patients and families would not normally be shared in the public domain. For these reasons monitoring of compliance and effectiveness will be via a confidential planned audit using an appropriately sampled population. As a minimum the following elements will be monitored.

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Lead</th>
<th>Tool</th>
<th>Frequency of Report of Compliance</th>
<th>Report arrangement</th>
<th>Lead(s) for acting on recommendations</th>
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<tbody>
<tr>
<td>Duty of Candour requirements are completed in 100% of cases</td>
<td>Head of Risk Management</td>
<td>DatixWeb</td>
<td>Monthly</td>
<td>Integrated Performance Report</td>
<td>Local/Divisional Management Teams:</td>
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APPENDIX A: DUTY OF CANDOUR REQUIREMENTS

- Of primary concern is ensuring that the patient and or their family/carer are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and are supported to deal with the consequences.

Duty of candour applies to patient safety incidents that result in moderate or severe harm or death. It does not apply to low, no harm or near miss events but this does not negate the requirement to inform the patient if appropriate, and we should apply the same principles of openness and honesty.

- The initial notification should be undertaken as soon as practicable and must be verbal and, where possible, face to face. It should be conducted in person by one or more representatives of the Trust and include where possible the clinician responsible for the episode of care, unless the patient cannot be contacted in person or declines notification. It is important to take into account any circumstances that will affect the ease of communication with the patient (language barriers, communication difficulties, or relevant disability).

This initial contact with the patient or relatives/carer must include the following:
  - A sincere apology.
  - A step-by step explanation, in plain English, of what happened, based on the known facts – this can be an initial view pending the outcome of an investigation.

- Once the incident is confirmed at the initial review panel meeting, a letter must be sent confirming the initial discussions, explaining what level of investigation will be conducted, inviting the patient/relative or carer to contribute to the terms of reference, and that when concluded the outcome/report will be shared.

Any further information that results from the investigation, or is subsequent to the initial explanation, must be offered to be provided to the patient or relatives/carer promptly and on a regular basis as the investigation progresses.

- Once the investigation has been concluded and ‘signed off’ as closed by the Trust, a copy of the final investigation report must be provided to the patient or relatives/carer or, preferably, a meeting arranged to share the report within 10 working days, unless this has been expressly declined.

- Full written documentation of all contact, either verbal or face to face, must be maintained and attached to the SLE report on Datix.

- If the patient or their family/carer declines any offers of meetings or to have information provided this must also be clearly recorded.

DUTIES AND RESPONSIBILITIES

- Patient Safety Team: has responsibility for providing support and advice to managers and staff to ensure that this policy is implemented across the Trust.

- Associate Chief Nurse for Patient Safety: has responsibility for the strategic implementation of this policy.

- Divisional Leadership Teams: have responsibility for ensuring that Being Open and Duty of Candour requirements are appropriately implemented and supported in the Divisions and Care Groups and for fostering a culture of learning, including any required changes in practice identified as a result of the Being Open process.

- All healthcare Professionals: it is expected that every healthcare professional should be open and honest with patients.
• Senior Healthcare Professionals: it is expected that, in the event of a serious event, the most senior healthcare professional involved in the patient’s care will be the individual who has primary communication with the patient.

• Nominated Person for Contact with Patient/Family: Once requirement for Duty of Candour is verified, nominated person to undertake the Duty of Candour process.
APPENDIX B: DUTY OF CANDOUR LETTER TEMPLATES

PRIVATE AND CONFIDENTIAL

(Insert contact address and telephone number)

Dear [name the person likes to be known as - based on nursing documentation]

As Dr/Nurse [name and designation] explained to you on [insert date of conversation], when you were recently receiving care at [insert location of incident][insert brief description of the incident and what has previously been discussed].

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

We would like the opportunity to discuss and share the findings of our investigation with you, and therefore once the investigation has concluded, I will like to invite you to a meeting to share the report and answer any questions you may have. This meeting can be arranged at a mutually convenient time and you can bring a relative or friend with you if you wish.

However, there is absolutely no pressure for you to come and talk to us. We just want to give you the opportunity, should you wish to do so. If you would prefer not to participate in the investigation or hear about its outcome, you need do nothing further.

The investigation process can take up to 60 working days to complete. I will be your lead contact during this time and you can call [me/my secretary] on the number at the top of this letter or, if you prefer, write to me. I would be very grateful to hear from you to confirm that you would like to be contacted regarding sharing the report or to know whether you have any questions about the investigation process.

Yours Sincerely,
PRIVATE AND CONFIDENTIAL

(Insert date)

(Insert name and address)

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

Dear [name]

Your [Mother/Father/Son etc] was recently receiving care at Queen Alexandra hospital and as Dr/Nurse [name and designation] has explained to you, [enter brief description of the incident and what has previously been discussed], whilst your [Mother/Father/Son etc] was a patient on [ward]

I would like to express my sincere apologies that this event has occurred while [name of patient] was under our care. I would also like to assure you that because the Trust aims to provide a quality service to all our patients, we are undertaking a full investigation into what occurred in an effort to understand exactly what happened and to find out if there is something that we could do differently to stop this from happening to anyone else in future.

We would like the opportunity to discuss and share our findings with you and therefore, once the investigation has concluded, I will invite you to a meeting to share the report and answer any questions you may have. This meeting can be arranged at a mutually convenient time and you can bring a relative or friend with you if you wish.

However, there is absolutely no pressure for you to come and talk to us. We just want to give you the opportunity, should you wish to do so. If you would prefer not to participate in the investigation or hear about its outcome, you need do nothing further.

The investigation process can take up to 60 working days to complete. I will be your lead contact during this time and you can call [me/my secretary] on the number at the top of this letter or, if you prefer, write to me. I would be very grateful to hear from you to confirm that you would like to be contacted regarding sharing the report or to know whether you have any questions about the investigation process.

Yours Sincerely,
Letter to be sent to relatives where the patient has died

Dear [name]

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

Your [Mother/Father/Son etc] was recently receiving care at Queen Alexandra hospital and as Dr/Nurse [name and designation] has explained to you, [enter brief description of the incident and what has previously been discussed], whilst your [Mother/Father/Son etc] was a patient on [ward]

I would like to express my sincere apologies that this event has occurred while [name of patient] was under our care. I would also like to assure you that because the Trust aims to provide a quality service to all our patients, we are undertaking a full investigation into what occurred in an effort to understand exactly what happened and to find out if there is something that we could do differently to stop this from happening to anyone else in future.

We would like the opportunity to discuss and share our findings with you and therefore, once the investigation has concluded, I will invite you to a meeting to share the report and answer any questions you may have. This meeting can be arranged at a mutually convenient time and you can bring a relative or friend with you if you wish.

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The investigation process can take up to 60 working days to complete. I will be your lead contact during this time and you can call [me/my secretary] on the number at the top of this letter or, if you prefer, write to me. I would be very grateful to hear from you to confirm that you would like to be contacted regarding sharing the report or to know whether you have any questions about the investigation process.

Yours Sincerely,
APPENDIX C: SPECIAL CIRCUMSTANCES

The approach to Being Open may need to be modified according to the patient's personal circumstances.

When a patient dies
When an event has resulted in a patient’s death, it is crucial that communication is sensitive, empathetic and open. It is important to consider the emotional state of bereaved relatives or carers 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 counseling or assistance at any stage.

Usually the Duty of Candour/Being Open discussion and any investigation occurs before the coroner’s inquest. But in certain circumstances the Trust may consider it appropriate to wait for the coroner’s inquest before holding the Being Open 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.

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 Being Open process. The opportunity for parents to be involved should still be offered 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 in the Trust’s Consent Policy or the Department of Health’s website: www.dh.gov.uk

Patients with mental health issues
Duty of Candour/Being Open for patients with mental health issues should follow normal procedures, unless the patient also has cognitive impairment (see below). The only circumstances in which it is appropriate to withhold information about an event from a mentally ill patient is when advised to do so by a consultant psychiatrist who feels it would cause adverse psychological harm. However, such circumstances are rare and a second opinion (by another consultant psychiatrist) would be needed to justify withholding information from the patient. Apart from in exceptional circumstances, it is never appropriate to discuss information about any event with a carer or relative without the 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 a health and welfare lasting 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/Being Open 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 with whom is the appropriate person is to discuss information 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 discussions about what has happened. An advocate with appropriate skills should be available to the patient, to assist in the communication process.

**Patients with learning disabilities**
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/Being Open process by alternative communication methods e.g. by being given the opportunity to write questions down. An advocate, agreed on in consultation with the patient, should be appointed. Appropriate advocates may include carers, the LD Liaison team family or friends of the patient and should focus on ensuring that the patient’s views are considered and discussed.

**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 the 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/Being Open process. In this case the following strategies may assist:

- Deal with the issue as soon as it arises.
- 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 healthcare professional is not aware of the relationship difficulties, provide the 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 nursing/medical team or the Patient and Customer Service team.
- Use a mutually acceptable mediator to help identify the issues between the healthcare professional and the patient, and to look for a mutually agreeable solution.
- Ensure the patient and/or their carers are fully aware of the complaints procedure.
- Write a comprehensive list of the points with which the patient and/or their carer disagree and reassure them you will follow up on these issues.

**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 information about any event. 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 Being Open process, focusing on the needs of the individuals and their families and being personally thoughtful and respectful.
First Phase – Open the Discussion

The Being Open lead should consider the process and key objectives when opening the initial discussion

Key ‘Dos’

- Do come to the meeting properly prepared
- Do advise the patient and/or family/carer of the identity and role of all the people attending the Being Open discussion before it takes place (this allows them the opportunity to state their own preferences about which healthcare staff should be present)
- Do introduce everyone present
- Do reiterate each person’s role. Ask the patient/family/carer if they are happy with who is involved
- Do start of the discussion by acknowledging that an incident has occurred and then express your sincere regret and sympathy.
- Do apologise on behalf of the team and the organization for what has happened – remember that patients expect and deserve an apology and an explanation following an incident
- Do outline the purpose of the discussion from the organisation’s perspective
- Do ask the patient/family/carer what else they would like to discuss in the meeting that may not be covered by the agenda outlined
- Do formally note the patient/family/carer’s views and concerns to demonstrate that these are being heard and taken seriously
- Do use appropriate language and terminology when speaking to patients/family/carers, for example using the terms ‘patient safety incident’ or ‘safety learning event’ may be at best meaningless and at worst insulting
- Do consider their language needs if the mother tongue is not English – the discussion should be arranged to be conducted in the appropriate language if necessary.
- Do use appropriate body language and eye contact from the outset of the discussion
- Do alleviate any immediate concerns, reassure the patient/family/carer that the harm done will be medically redressed, if appropriate

Key ‘Don’ts’

- DON’T deny responsibility
- DON’T be defensive or treat the patient as an adversary
- DON’T use technical medical jargon
- DON’T say ‘no comment’ or go ‘off the record’

Second Phase – Discussion of the Incident

The Being Open lead should consider the process and key objectives when discussing the incident.

Key ‘Do’s’

- Do provide reassurance that the matter is being taken seriously and that everything possible will be done to make sure that the same incident does not happen again
- Do establish what the patient/family/carer knows about the patient safety incident already so you can clarify or provide further information appropriate to their needs (e.g. can you tell me what happened from your point of view?)
- Do communicate the facts of the incident as they are known at the time, giving an honest account of what happened
- Do stick to the facts of the incident as they are known at the time
- Do emphasize that more information may come to light as the investigation progresses
- Do answer any questions as you discuss the incident as well as asking if they have any further questions when you have finished explaining what happened
- Do acknowledge the patient/family/carer’s views and concerns and keep a written record of them to demonstrate that these are being heard and taken seriously
• Do check and verify that the patient has understood what you have told them – asking them to recount what has been said is usually the best way to check how much information they have taken in, however be mindful that this may be too distressing at the time.
• Do record key action points and assign responsibilities and deadlines

Key ‘Don’ts’

• DON’T exaggerate or speculate
• DON’T blame or criticize your colleagues
• DON’T be defensive or treat the patient as an adversary
• DON’T use technical medical jargon
• DON’T withhold information (unless, in very rare circumstances, information regarding a patient safety incident is likely to put the patient at additional risk)
• DON’T provide conflicting information from different individuals
• DON’T say ‘no comment’ or go ‘off the record’

Third Phase – Outlining Next Steps

Key ‘Dos’

• Do provide reassurance that the matter is being taken seriously and that everything possible will be done to make sure that the same incident does not happen again
• Do explain the incident investigation process clearly and in simple terms that the patient/family/carer can understand
• Do emphasize that more information may come to light as the incident investigation progresses
• Do state what outcome the patient can expect from the incident investigation process
• Do provide reassurance that the investigation process will be open and fair and that the final report will be available for them to see
• Do explain what will happen next in terms of the long term treatment plan (as appropriate) and incident analysis findings
• Do share information on likely short term and long term effects of the incident if known (this may have to be delayed to a subsequent meeting when the situation becomes clearer)
• Do check and verify that the patient has understood what you have told them – asking them to recount what has been said is usually the best way to check how much information they have taken in, however be mindful that this may be too distressing at the time.
• Do offer the patient/family/carer support and counseling which would include bereavement counseling, where appropriate
• Do remember many patients and their families are unsure of what to ask so always ask if they have any further questions.
• Do assign a healthcare professional to liaise with the patient throughout the investigation process and confirm their point of contact at the end of the meeting
• Do reiterate your role in the Being Open process and offer contact details if necessary and if different from the healthcare professional assigned to liaise with the family
• Do emphasize to the patient that Being Open is a process and not a one off event and if they have more questions to not hesitate to contact the Being Open lead
• Do record key action points and assign responsibilities and deadlines
• Do clarify in writing the information given, reiterate the key points discussed at the meeting
• Do ensure that on-going communication takes place, the next steps are carried out and the Being Open process is completed

Key ‘Don’ts’

• DON’T use technical medical jargon
• DON’T forget that the initial Being Open discussion is the first part of an ongoing communication process and many of these points may be expanded in subsequent meetings
## Stage 1 - Screening

**Title of Procedural Document**: Duty of Candour and being Open Policy

<table>
<thead>
<tr>
<th>Date of assessment</th>
<th>Responsible Department</th>
<th>Name of person completing assessment</th>
<th>Job Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 August 2019</td>
<td>Risk Management</td>
<td>Annie Green</td>
<td>Head of Risk Management</td>
</tr>
</tbody>
</table>

Does the policy/function affect one group less or more favourably than another on the basis of:

<table>
<thead>
<tr>
<th>Yes/No</th>
<th>Comments</th>
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<td>No</td>
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- Age
- Disability: Learning disability; physical disability; sensory impairment and/or mental health problems e.g. dementia
- Ethnic Origin (including gypsies and travellers)
- Gender reassignment
- Pregnancy or Maternity
- Race
- Sex
- Religion and Belief
- Sexual Orientation

If the answer to all of the above questions is NO, the EIA is complete. If YES, a full impact assessment is required: go on to stage 2, page 2

More Information can be found by following the link below

www.legislation.gov.uk/ukpga/2010/15/contents

## Stage 2 – Full Impact Assessment

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<thead>
<tr>
<th>What is the impact</th>
<th>Level of Impact</th>
<th>Mitigating Actions (what needs to be done to minimise / remove the impact)</th>
<th>Responsible Officer</th>
</tr>
</thead>
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</tbody>
</table>

**Monitoring of Actions**

The monitoring of actions to mitigate any impact will be undertaken at the appropriate level:

- Specialty Procedural Document: Specialty Governance Committee
- Care Group Procedural Document: Divisional Governance Committee
- Corporate Procedural Document: Relevant Corporate Committee

All actions will be further monitored as part of reporting schedule to the Equality and Diversity Committee.