Western Health and Social Care Trust

Being Open Policy
June 2021

Western Health and Social Care Trust

Policy Code: MED21/001

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Western Health and Social Care Trust

Contents

1.0 INTRODUCTION / PURPOSE OF POLICY

When things go wrong harm may occur. This can have devastating emotional and physical consequences on the individual, their family and carers, and can be distressing for the professionals involved.

'Being Open' is a set of principles that health and social care staff should use when offering an explanation and apologising to service users and/or their carers when harm has resulted from an incident.

"saying sorry is not an admission of liability"

Being Open' involves:

- acknowledging, apologising and explaining when things go wrong;
- keeping service users and carers fully informed when an incident has occurred;
- conducting a thorough investigation into the incident and reassuring service users, their families and carers that lessons learned will help prevent the incident recurring;
- providing support for those involved to cope with the physical and psychological consequences of what happened;
- recognising that direct and/or indirect involvement in incidents can be distressing for health and social care staff, permission will be given to seek emotional support.

The organisation is committed to improving the safety and quality of the care we deliver to the public. This '*Being Open'* policy expresses this commitment to provide open and honest communication between health and social care staff and a service user (and/or their family and carers) when they have suffered harm as a result of their treatment. It is based on published guidance by the National Patient Safety Agency (NPSA) and also complies with step 5 of '*Seven Steps to Patient Safety'* (Appendix 1).

1.1 Background

1.1.1 Openness and honesty towards service users are supported and actively encouraged by many professional bodies including the General Medical Council, the Royal College of Nursing, the Medical Defence Union and the Medical Protection Society.

The duty of candour has received support through the Joint statement from the Chief Executives of statutory regulators of healthcare professionals.

This is supported by *Openness and honesty when things go wrong: the professional duty of candour*, issued by the GMC and NMC in 2015 summarising their position on this and provides guidance on how to follow the principles set out in *Good Medical Practice* (GMC) and *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC)

In September 2005 the National Patient Safety Agency (NPSA) called on all NHS organisations to develop local '*Being Open'* policies. Their guidance was replaced in November 2009 by *Being Open: communicating service user safety incidents with service users, their families and carers* in response to changes in the health and social care environment and in order to strengthen '*Being Open'* throughout the NHS (see appendix 6).

They also produced a *Being Open Framework* to act as a best practice guide on how to create an open and honest environment through:

- aligning with the Seven steps to patient safety (Appendix 1) which outlines for leaders of health and social care organisations how to create an open and fair culture;
- ensuring a '*Being Open'* policy is developed that clearly describes the process to be followed when harm occurs. This relates directly to, and expands upon, step 5;
- committing publicly to '*Being Open'* at board and senior management level;
- identifying senior clinical counsellors to mentor and support fellow health and social care professionals involved in incidents.

This policy is based upon adopting openness, transparency and candour throughout the organisation and is modelled on the NPSA *Being Open* policy and the '*Being Open'* Framework document.

1.1.2 Recommendations from Inquiry Reports

In recent years there have been a number of reports arising from diverse inquiries into health and social care both in England and Northern Ireland and all of these have included recommendations in regard to Being Open and Duty of Candour. The summary of the relevant recommendations are in **Appendix 8** and include the Francis Report (2013), the Donaldson Report (2014) and the Hyponatraemia Inquiry (O'Hara 2018).

Although there is currently no statutory duty of candour in Northern Ireland, as recommended by the Donaldson and O'Hara reports, the suggestion has been endorsed by previous Northern Ireland health ministers. Furthermore, work is ongoing to implement the recommendations arising from the O'Hara Report through the IHRD Implementation Programme. This work includes the

introduction of a statutory duty of candour and a revised regional Being Open policy, which will eventually replace this policy.

1.1.3 The organisation will have the following foundations to implement '*Being Open'* successfully:

A. Open and fair culture

Promoting a culture of openness is vital to improving service user safety and the quality of health and social care systems. A culture of openness is one where health and social care:

- staff are open about incidents they have been involved in;
- staff and organisations are accountable for their actions;
- staff feel able to talk to their colleagues and superiors about any incident;
- organisations are open with service users, the public and staff when things have gone wrong and explain what lessons will be learned;
- staff are treated fairly and are supported when an incident happens.

To achieve this goal of openness with the public, the organisation has adopted the nationally recognized seven steps to patient safety in their risk management strategy and will continuously strive to achieve these objectives contained within the steps (Appendix 1).

To implement '*Being Open'* successfully, the organisation will have the following foundations:
A. a culture that is open and fair;
B. a '*Being Open'* policy and mechanisms to raise awareness about it;
C. staff and service user support for '*Being Open'.*

B. 'Being Open' policy & associated training

A *'Being Open'* policy that sets out the process of communication with service users, and raising awareness about this, will provide staff with the confidence to communicate effectively following an incident.

A training programme that provides information on the fundamentals of applying the Being Open Process and includes a case study will be made available for staff.

C. Staff and service user support

To ensure both staff and service users support the implementation of *'Being Open'* it is vital that:

- Service users, their families and carers feel confident in the openness of the communication following a service user safety incident, including the provision of timely and accurate information;
- health and social care professionals understand the importance of openness and feel supported by their health and social care organisation in

delivering it, and that where appropriate they undertake the Being Open e-learning programme.

Appendix 3 describes the benefits of being open and honest for both staff and service users.

1.1.4 Prevented and 'no harm' incidents

The Trust encourages staff to report all service user safety incidents; even those that were prevented (i.e. 'near misses'), insignificant and minor incidents. These are often the type of incidents which, if addressed promptly and taken seriously, will lead to minimising or preventing more serious incidents. This monitoring of all incidents will lead to the achievement of a high quality safety culture.

It is not a requirement of these guidelines that prevented and no harm service user safety incidents are discussed with service users as this would cause undue and unnecessary anxiety. This does not absolve staff of their responsibility to report such incidents to ensure that they are recorded, monitored and reported through the Trust incident reporting system.

1.1.5 Being Open

The main thrust of this 'Being Open' policy is concerned with service user safety incidents which cause moderate, major or catastrophic harm (Appendix 2). It describes the process of 'Being Open' and gives advice on the 'do's and don'ts' of communicating with service users and/or their carers following harm.

The focus is on rapid and open disclosure and emotional support to service users and families who experience serious incidents. They also address ways to support and educate clinicians involved in such incidents.

The Trust will approach these issues from the service user's point of view, asking, "What would I want if I were harmed by my treatment?"

While Trust employees and caregivers may have competing interests, including legitimate concerns about legal liability, our frame of reference is the simple question, "What is the right thing to do?"

1.1.6 Definitions

Harm is defined as injury (physical or psychological), disease, suffering, disability or death. In most instances it can be considered to be unexpected if it is not related to the natural cause of the service user illness or underlying condition. The injury or damage can be described as physical, psychological (or both), suffering, disability or death. It can be rated as insignificant, minor, moderate, major or catastrophic (Appendix 2).

Service User[1]: this term refers to a patient, service user, family (of a service user and/or family of a victim), carer or nominated representative.

1.2 Purpose

This document is relevant to all board, executive, managerial and health and social care staff and by explaining the principles behind '*Being Open'* it ensures that service users and families who experience incidents which have caused moderate, major or catastrophic harm receive rapid and open disclosure along with emotional support. It also addresses ways to support and educate staff involved in such incidents.

1.3 Objectives

This policy defines the organisation's commitment to '*Being Open'* by establishing a culture where:

- service users and carers receive rapid and open disclosure and emotional support when they experience serious incidents which cause moderate, major or catastrophic harm;
- they receive the information they need to enable them to understand what happened and the reassurance that everything possible will be done to ensure that a similar type of incident does not occur again;
- ways to support and educate health and social care staff involved in such incidents are addressed;
- staff involved are treated justly and appropriately;
- health and social care professionals, managers, service users and carers are appropriately supported when things go wrong;
- Service users and carers receive timely information about the outcome of any investigation.

2.0 SCOPE OF THE POLICY

The *Adverse Incidents policy* encourages staff to report all service user safety incidents, including those where there was no harm or it was a 'near miss' event.

The *'Being Open'* **principles** apply to any incident where any harm has occurred to a service user. The *'Being Open'* **process** outlined in the policy must be followed where incidents are of moderate, major or catastrophic severity as defined in Appendix 2 a and b. Incidents that are regarded as insignificant or minor do not require implementation of the Being Open process,

This policy applies to all Trust employees.

[1] As per the draft Statement of what you should expect in relation to a Serious Adverse Incident Review, January 2019

This policy establishes a culture of openness as a basic principle of how we interact with service users which then underpins other policies.

It also complements standards as set out by professional bodies e.g. GMC and NMC.

3.0 ROLES/RESPONSIBILITIES

This policy is aimed at all levels of health and social care staff. The following responsibilities and accountabilities reinforce the concept of this *'Being Open'* culture of openness applying throughout the organization.

Trust Board

The Trust Board are responsible:

- For seeking assurance that a robust system is in place to support openness with service users following an incident as appropriate.
- for actively championing the *'Being Open'* process;
- for promoting an open and fair culture that fosters peer support and discourages the attribution of blame. This should result in staff being empowered to improve service user care by learning from mistakes rather than denying them.

Chief Executive

The Chief Executive is responsible for ensuring the infrastructure is in place to support openness between health and social care professionals and service users and/or their carers following an incident that led to moderate, major or catastrophic harm.

Executive Directors

Medical Director

Overall professional responsibility for managing the '*Being Open'* process.

Service Directors

Responsibility within their own service directorate for managing the '*Being Open'* process.

Managers

- Ensure all staff are aware of the "Being Open" policy.
- Support staff, particularly those who will have a key role in managing the being open process.
- Support staff involved in service user safety incidents, including advising on sources of appropriate support such as the Inspire Service.

- Notify the
  - Assistant Director when an incident has caused moderate harm or more.
  - Risk Management Department and the relevant Assistant Director that the 'Being Open' process has been initiated for an incident causing major or catastrophic harm.

All Health and social care Staff

All staff working within the organisation will be expected to adhere to this policy and are responsible and accountable for:

- ensuring that service user incidents are acknowledged and taken seriously;
- treating concerns with compassion and understanding;
- reporting as soon as they are identified;
- informing their line manager;
- participating in the investigation process;
- communicating in a timely, truthful & clear fashion;
- recording and documenting discussions with service users and families;
- complying with the *Being Open* policy;
- undertaking the Being Open e-learning programme where appropriate.

4.0 KEY POLICY PRINCIPLES

4.1 Key Policy Statement(s)

Service user safety incidents will be managed using the principles outlined in this '*Being Open'* policy. Each incident will trigger a 5 stage process as set out in Appendix 4; with modifications in certain circumstances detailed in Appendix 5.

4.2 The principles of 'Being Open' should also apply to the full spectrum of unexpected or unplanned clinical events. Especially where there is a risk of moderate, major or catastrophic harm, a rapid and open disclosure of these changes in a service user's medical condition e.g. C. Diff. infection or a fall resulting in major injury eg, fracture/haemorrhage, should be communicated and discussed with the service user and, where appropriate, their family.

Also, in keeping with the 'Being Open' philosophy, if a death certificate is needed it is the responsibility of the Consultant to ensure that it is completed accurately and that the details of the service user's illness, its treatment and the factors causing and/or contributing to the service user's death are discussed with the relatives and recorded in the clinical record.

4.3 All service user safety incidents will be **acknowledged** and reported as soon as possible in line with the Adverse Incident policy; denial of a concern makes further open and honest communication more difficult.

4.4 The most appropriate person must **communicate** with the service user about an incident in a truthful open and timely manner. Information must be based solely on the facts. Service users will not receive conflicting information from different members of staff.

4.5 Service users and/or their families [unless there are confidentiality issues] will receive a sincere **apology** and expression of sorrow or regret for the harm caused by a service user safety incident.

10 principles of 'Being Open'

1. Acknowledge incident
2. Communicate – truthful, timely, clear
3. Apology
4. Service user, family & carer support
5. Support for Professions
6. Risk management
7. Multidisciplinary responsibility
8. Clinical Governance
9. Confidentiality
10. Continuity of care

Both verbal and written apologies will be given. Verbal apologies are essential because this allows face-to-face contact and they should be given as soon as staff are aware of the incident. Delay is likely to increase anxiety, anger or frustration.

The NI Ombudsman has issued a 'Guidance on Issuing an Apology' leaflet which provides helpful guidelines regarding issuing an apology (Appendix 7).

4.6 Support for the Service user

A key part of 'Being Open' is considering the service user's needs, or the needs of their carers or family in circumstances where the service user has been involved in a serious service user safety incident or died. The Trust will ensure early identification of, and provision for, the service user's practical and emotional needs.

Service users and/or their carers can reasonably expect to be kept fully informed of the issues surrounding a service user safety incident in a face-to-face meeting. They will be treated sympathetically with respect and consideration. They will be provided with **support** in a manner appropriate to their needs.

This includes providing the names of people who can give assistance and support, and to whom the service user has agreed that information about their health care can be given. This person (or people) may be different to both the service user's next of kin and from people whom the service user had previously agreed should receive information about their care prior to the service user safety incident.

The Trust will provide information on services offered by all the possible support agencies (including their contact details) that can give emotional support, help the service user identify the issues of concern, support them at meetings with staff and provide information about appropriate community services.

Contact details will be provided of a staff member who will maintain an ongoing relationship with the service user, using the most appropriate method of communication from the service user's and/or their carer's perspective. Their role is to provide both practical and emotional support in a timely manner.

Public information statement
'*Being Open*' if things go wrong:
We will
- tell you if we know something has gone wrong;
- listen to you if you see something is wrong;
- say sorry;
- find out what happened and why;
- keep you informed;
- answer your questions;
- work to stop it happening again.

It is important to identify at the outset if there are any special restrictions on openness that the service user would like the health and social care team to respect. It is also important to identify whether the service user does not wish to know every aspect of what went wrong, to respect their wishes and reassure them this information will be made available if they change their mind later on.

4.7 Support for Families, Carers

Service users and/or their carers may need considerable practical and emotional help and support after experiencing a service user safety incident. Support may be provided by service users' families, social workers, religious representatives, service leads and Family Liaison Officer for SAIs. Details of the Service User Client Council should also be available among others. Where the service user needs more detailed long-term emotional support, advice should be provided on how to gain access to appropriate counselling services, e.g. Cruse.

A service user and/or their family may, at any time through this process wish to avail of advocacy or representation if they feel this would help them to understand and address issues.

4.8 Support for staff

These guidelines apply to all staff that have a role in providing service user care. The Trust acknowledges that most incidents usually result from system failures and it is unusual that incidents arise solely from the actions of an individual. Senior managers and senior clinicians must participate in incident investigation and clinical risk management.

When a service user safety incident occurs, health and social care professionals involved in the clinical care may also require emotional support and advice. Both the staff who have been involved directly in the incident and those with the responsibility for '*Being Open'* discussions should be given access to assistance, support and any information they need to fulfil this role.

Please refer to the Trust policy on Supporting Staff Involved in Incidents for further details.

To **support staff** involved the Trust will:

- Actively promote an open and fair culture that fosters peer support and discourages the attribution of blame. The Trust will work towards a culture where blame is the enemy of learning and where human error is understood to be a consequence of flaws in the health and social care systems, not necessarily the individual;
- Create an environment in which staff are encouraged to report service user safety incidents. Staff should feel supported throughout any incident investigation process;
- Provide facilities for formal and informal debriefing of the clinical team involved in an incident separate from the requirement to provide statements for the investigation. Individual feedback about the final outcome of the service user safety incident will be available;
- Provide advice and training on the management of service user safety incidents;
- Provide counselling by professional bodies for staff distressed by service user safety incidents. Stress management courses for staff that have responsibilities for leading "Being Open" discussion;
- Avail of the support services provided by staff representative organisations and ensure staff have access to the information they can provide;
- Recognise that there is a need for health and social care staff to develop the skills necessary to be effective when communicating with service users and/or their carers in these rare but very distressing circumstances. The Trust will provide training to assist communicating in these difficult situations.

4.9 Service user safety incidents will be investigated to uncover the underlying cause(s). Investigations should focus on improving systems of care. The '*Being Open*' policy is part of an integrated approach to addressing service user safety incidents. They are embedded in an approach to **risk management** that includes incident reporting, analysis of incidents and decision about staff accountability.

4.10 This policy applies to all members of the **multidisciplinary teams** that have key roles in providing the service user's care. This should be reflected in the way that service users, their families and carers are communicated with when things go wrong. This will ensure that the '*Being Open'* process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual.

To ensure multidisciplinary involvement in the '*Being Open'* process, it is important to identify clinicians, nurses and managers who will support it. Both senior managers and senior clinicians who are local leaders must participate in incident investigation and clinical risk management.

4.11 The guidelines will require support of service user safety and quality improvement processes through the assurance and **governance framework** in which service user safety incidents are investigated and analysed and to find out what can be done to prevent a recurrence.

The findings of any investigation should be disseminated to all relevant persons and monitored so they can learn from events. This will also facilitate the move towards increased awareness of service user safety issues and the value of '*Being Open'*.

4.12 Full **confidentiality** of and respect for service users, carers and staff will be maintained. Consent will be sought from individuals prior to disclosing information beyond the clinicians involved in treating service users. Communication with parties outside of the clinical team should also be on a strictly need-to-know basis.

4.13 Service users are entitled to expect, and the Trust will ensure, that they will receive **continuity of care** with all the usual treatment and continue to be treated with dignity, respect and compassion. If a service user expresses a preference for their health and social care needs to be taken over by another team, the Trust will make every effort to make the appropriate arrangements unless it is clearly obvious not to be in the service user's best interests.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This policy covers all areas of the organisation's business and applies to all incidents involving service users. All staff employed by the Trust should be provided with access to this policy. The latest version of this policy (and related documents) is available on the Trust's intranet.

5.2 Resources

5.2.1 Training

Adverse Incident Training is mandatory for all staff and appropriate training and guidance will be provided by of the Risk Management Department to ensure that all Trust employees understand their responsibilities under this policy and are able to effectively fulfil their obligations to being open following adverse incidents. The organisation's training administration system (HRPTS) should be used appropriately to record staff training. Senior Managers/Heads of Departments are responsible for ensuring that their staff avail of training on Incident Reporting and Being Open.

The AD responsible for an SAI must ensure that their nominee to liaise with the patient/family (where applicable) has experience and training in communicating with the service user / family.

6.0 MONITORING

This policy will be audited through the Quality & Safety department. As per IHRD recommendations, Risk Management will facilitate monitoring of compliance through a specific field on Datix regarding engagement which will be reported at Directorate Governance and Clinical & Social Care Governance Sub-Committee.

7.0 EVIDENCE BASE / REFERENCES

Incident Reporting and Management Policy
Risk Management Strategy
National Patient Safety Agency documents
Australian Open Disclosure Framework
Seven steps to patient safety: full reference guide – (NPSA July 2004)
Being open: communicating patient safety incidents with patients, their families and carers (NPSA, 2009)
'Being Open' Framework – (NPSA, November 2009)
Openness & Honesty when things go wrong: the professional duty of candour (NMC/GMC 2015)
https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/openness-and-honesty-professional-duty-of-candour.pdf
The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report) (Feb, 2013)
Right time, right Place (Donaldson Report) (2014)
Inquiry into Hyponatraemia-related Deaths (O'Hara) (2018)
Guidance on issuing an apology, NIPSO June 2016
https://nipso.org.uk/site/wp-content/uploads/2018/05/N14C-A4-NIPSO-Guidance-on-issuing-an-apology-June-2016-1.pdf

8.0 CONSULTATION PROCESS

Via Regional Adverse Incident Working Group.

9.0 APPENDICES / ATTACHMENTS

Appendix 1:	Seven steps to patient safety
Appendix 2a:	Grade and definition of patient safety incident
Appendix 2b:	Grades and consequent actions following Service User Safety Incidents
Appendix 3:	Benefits for Service Users and Staff
Appendix 4:	The '*Being Open'* process
Appendix 5:	Being open in particular circumstances
Appendix 6:	NPSA '*Being Open'* safety alert November 2009
Appendix 7:	Guidance on issuing an apology – NI Ombudsman
Appendix 8:	Inquiry reports relating to duty of candour

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.

The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☒

SIGNATORIES

_____ **Date:** _____

_____ **Date:** _____

APPENDIX 1 – NPSA – Seven steps to patient safety

National Patient Safety Agency. *Seven steps to patient safety. The full reference guide*. 2004.

APPENDIX 2a – Grade and Definitions of patient safety incident

Definitions for grading of Service User Safety Incidents

Insignificant

Incident prevented / Near Miss
Any service user safety incident that had the potential to cause harm but was prevented and no harm was caused to service users receiving NHS-funded care. Incidents that did not lead to harm but could have, are referred to as near misses. (*Doing Less Harm. NHS. National Patient Safety Agency 2001*).

Incident not prevented
Any service user safety incident that occurred but insignificant harm was caused to service users receiving NHS-funded care.

Minor harm

Any service user safety incident that required:

- *Minor injury or illness requiring first aid/intervention;*
- *Requiring increased service user monitoring;*
- *Increase in hospital stay by 1-3 days.*

Moderate harm

Any service user safety incident that resulted in a moderate increase in treatment* and that caused significant but not permanent harm to one or more service users receiving NHS funded care.

**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 outservice user, cancelling of treatment, or transfer to another area such as intensive care as a result of the incident.*

Major harm

Any service user safety incident that appears to have resulted in permanent harm* to one or more service users receiving NHS-funded care.

**Permanent harm directly related to the incident and not related to the natural course of the service user's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiological or intellectual, including removal of the wrong limb or organ, or brain damage.*

Catastrophic

Any service user safety incident that directly resulted in the death* of one or more service users receiving NHS-funded care.

**The death must be related to the incident rather than to the natural course of the service user's illness or underlying condition.*

APPENDIX 2b – Grades and consequent actions following Service User Safety Incidents – this section can be amended by each organisation – either keep information listed below or amend as per Regional Risk Matrix

	Insignificant	Minor	Moderate	Major	Catastrophic
Definition (see Risk Matrix also)	Near miss, no injury or harm.	•Short-term injury/minor harm requiring first aid/medical treatment.	Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year).	Long-term permanent harm/disability (physical/emotional injuries/trauma).	Incident leading to death.
Example		Intervention required. Requires first aid. Increased service user monitoring. Additional medication. Increased hospital stay (1-3 days). No return to surgery. No readmission.	Semi-permanent physical/ emotional injury/trauma/harm. Treatment given. Recovery expected within 1 year. Return to surgery. Unplanned readmission. Prolonged episode of care. Extra time in hospital (4-14 days) or as an outservice user. Cancellation of treatment. Transfer to another area e.g. ICU.	Permanent physical/ emotional injuries/trauma/ harm. Increased hospital stay >14 days.	The death must be related to the incident rather than to the natural course of the service user's illness or underlying condition.
Action	↓	↓	↓	↓	↓
	Apply the principles of 'Being Open'.		**Apply the 'Being Open' process Stages I →VI.**		
	1. Report the incident in line with the adverse incident reporting and management policy. 2. Review the incident to determine its cause and take local action to prevent it happening again. 3. The principles of the 'Being Open' policy apply but no documented actions are required.		A higher level of response is required in these circumstances. Report the incident in line with adverse incident reporting and management policy. The Governance Manager [insert relevant name] in your Directorate should be notified immediately and will be available to provide support and advice during the '*Being Open'* process if required.		

APPENDIX 3 – Benefits for Service Users and Staff

BENEFITS FOR SERVICE USERS

Being open when things go wrong has not always been part of the Health and Social Care culture. However evidence shows that being open and honest is fully supported by service users and they are more likely to forgive and understand health and social care errors when they have been discussed fully in a timely and thoughtful manner. Research and the feedback from those involved in a serious service user safety incident indicate that the service users would like:

- To know when a safety incident affects them;
- An acknowledgement of the distress that the incident caused;
- A sincere and compassionate statement of regret for the distress being experienced;
- A factual explanation of what happened;
- A clear statement of what is going to happen from then onwards;
- A plan about what can be done to repair or redress the harm done.

BENEFITS FOR STAFF

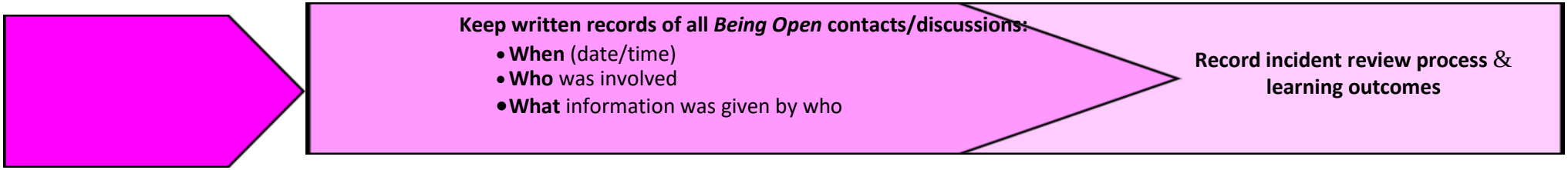
Being open has several benefits for health and social care staff including:

- Satisfaction that communication with service users and/or their carers following a service user safety incident has been handled in the most appropriate way;
- improving the understanding of incidents from the perspective of the service user and/or their carers;
- the knowledge that lessons learned from incidents will help prevent them happening again;
- having a good professional reputation for handling a difficult situation well and earning respect among peers and colleagues.

APPENDIX 4 – 'Being Open' Process

'Being Open' is a process rather than a one-off event and can be considered in 6 stages (stage 2 has 2 parts) with documentation being a constant feature throughout the process.

Stage I	Stage II		Stage III	Stage IV	Stage V
Service user incident detection and recognition	**Preliminary Team discussion**		**Initial Being Open meeting/contact**	**Follow-up meetings/ contacts**	**Being Open process completed**
	Inform service user/carer	**Plan further Being Open process**			
Service user safety incident recognised Prompt care and actions to prevent any further harm Incident reporting Identify staff and service user support & communication needs	**Minor** Initial assessment to determine level of response – grading Provide open honest factual information Offer initial verbal apology/expression of regret/sympathy Offer initial support Discuss further contacts	**Moderate, Major, Catastrophic** Establish the facts Decide the process Identify lead person & clarify if this is lead contact Agree with SU/Family who will meet with who when and where Identify support needed	Explain the process Offer apology/ regret/sympathy and support Provide factual details Explain learning process Invite questions/ comments/take notes Agree any further contact	Confirm meeting in writing and provide written apology Keep in touch as agreed at meeting Trust investigation process Feedback method agreed with SU/family	Feedback from the investigation process, learning and actions - to service users/ family and carers - to other Trust staff and partners Monitoring
No Being Open process required for near miss or no harm incidents	End of the Being Open process for low harm incidents		May be end of Being Open process or may agree further contact		End of Being Open process


Keep written records of all *Being Open* contacts/discussions:
• **When** (date/time)
• **Who** was involved
• **What** information was given by who
Record incident review process & **learning outcomes**

Details of Key Stages of Being Open Process

STAGE I: INCIDENT DETECTION AND MANAGEMENT

The '*Being Open'* process begins with the recognition that a service user has suffered moderate harm, major harm, or has died, as a result of a service user safety incident.

Detection of the incident

A service user safety incident may be identified by:

- a member of staff at the time of the incident;
- a member of staff retrospectively when an unexpected outcome is detected;
- a service user and/or their carers who expresses concern or dissatisfaction with the service user's health and social care either at the time of the incident or retrospectively;
- incident detection systems such as incident reporting or medical records review;
- other sources such as detection by other service users, visitors or non-clinical staff.

Priority

As soon as a service user safety incident is identified, the top priority is prompt and appropriate clinical care and prevention of further harm. Where additional treatment is required this should occur whenever reasonably practicable after a discussion with the service user and with appropriate consent. An incident report form should be completed which will trigger the Trust processes for reporting and then investigating and analysing incidents. If the incident is considered to meet Serious Adverse Incident criteria, the incident should also be escalated to the appropriate directorate senior manager and governance and quality manager to ensure timely appropriate management which may result in a serious adverse incident report to HSCB.

SERVICE USER safety incidents occurring elsewhere

A service user safety incident may have occurred outside the Trust. The individual who first identifies the possibility of an earlier service user safety incident should notify Corporate Governance. The same individual, or a colleague, should make contact with their equivalent at the organisation where the incident occurred and establish whether:

- the service user safety incident has already been recognized;
- the process of '*Being Open'* has commenced;
- incident investigation and analysis is underway.

The '*Being Open'* process and the investigation and analysis of a service user safety incident should occur where the incident took place.

Criminal or intentional unsafe act

Service user safety incidents are almost always unintentional. However, if at any stage following an incident it is determined that harm may have been the result of a criminal or intentional unsafe act, Corporate Governance Department and the relevant Executive Director should be notified immediately.

The WHSCT Adverse Incident Policy should be referred to.

STAGE II: INFORM SERVICE USER/CARER

Provide open honest factual information

Offer initial verbal apology / expression of regret / sympathy

An expression of genuine sympathy, regret and an apology for the harm that has occurred.

Appropriate language and terminology are used when speaking to service users, their families and carers.

Offer initial support

Staff should ensure the service user, their family and/or their carers:

- are informed that an incident investigation is being carried out if appropriate;
- show understanding of what happened is taken into consideration, as well as any questions they may have;
- are provided with information on the complaints procedure if they wish to have it.

Consideration and formal noting of the service user's, their family's and carers' views and concerns, and demonstration that these are being heard and taken seriously.

Discuss further contacts

An offer of practical and emotional support for the service user, their family and carers. This may involve getting help from third parties such as charities and voluntary organisations, as well as offering more direct assistance. Information about the service user and the incident should not normally be disclosed to third parties without consent.

Discussions with service users and/or their carers are documented and that information is shared with them.

This is the end of the Being Open process for low harm incidents

STAGE III: PRELIMINARY TEAM DISCUSSION/ Plan further Being Open Process

The multidisciplinary team, including the most senior health professional involved in the service user safety incident, should meet as soon as possible after the event to:

- establish the basic clinical and other facts;
- assess the incident to determine the level of immediate response;
- identify who will be responsible for discussion with the service user and/or their carers = '*Being Open'* coordinator;
- consider the appropriateness of engaging service user support at this early stage. This includes the use of a facilitator, a service user advocate or a health and social care professional that will be responsible for identifying the service user's needs and communicating them back to the health and social care team;
- identify immediate support needs for the health and social care staff involved;
- ensure there is a consistent approach by all team members around discussions with the service user and/or their carers.

Assessment to determine level of response

All incidents should be assessed initially by the health and social care team to determine the level of response required. The nature and subsequent grading of the incident will determine the level of response.

Incident	Level of Response
Insignificant harm (including prevented service user safety incident)	It is not a requirement of this policy to communicate prevented service user safety incidents and insignificant incidents to service users and/or carers.
Minor harm	Unless there are specific indications or the service user requests it, the communication, investigation and analysis, and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the incident. Communication should take the form of an open discussion between the staff providing the service user's care and the service user and/or their carers. Reporting to the corporate governance department will occur through standard incident reporting mechanisms and monthly data will provided to Directorate teams for analysis to detect high frequency events. Review will occur through aggregated trend data and local investigation. Where the trend data indicates a pattern of related events, further investigation and analysis may be needed. **↳Apply the principles of 'Being Open' – locally.**
Moderate harm **Major harm** **Death**	A higher level of response is required in these circumstances. Report the incident in line with adverse incident reporting and management policy. The Assistant Director with responsibility for Govenrance in your Directorate should be notified immediately and will be available to provide support and advice during the 'Being Open' process if required. **↳Apply the 'Being Open' process – Stages I → VI.**

Timing of discussion with service user and/or carers

Preliminary discussions with the service user and/or their carers should occur as soon as possible after recognition of the service user safety incident. This includes medication incidents. Factors to consider when timing this and any future '*Being Open*' discussions include:

- clinical condition of the service user;
- service user preference (i.e. meeting place and timing, who leads the discussion(s);
- availability of key staff involved in the incident and in the '*Being Open'* process;
- availability of the service user's family and/or carers;
- availability of support staff e.g. interpreter, independent advocate.

The *'Being Open'* coordinator role

It is essential to carefully consider the choice of the individual to communicate with service users and who informs the service user and/or their carers about a service user safety incident. Getting it right at the start of the process will reassure the service user and may lead to a favourable outcome.

This should be the most senior person responsible for the service user's care and/or someone with experience and expertise in the type of incident that has occurred. They should:

- be known to, and trusted by, the service user and/or their carers;
- have a good grasp of the facts relevant to the incident;
- be senior enough or have sufficient experience and expertise in relation to the type of service user safety incident to be credible to service users, carers and colleagues;
- have excellent interpersonal skills, including being able to communicate with service users 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 service users and/or their carers;
- be able to maintain a medium to long term relationship with the service user and/or their carers, where possible, and to provide continued support and information;
- be culturally aware and informed about the specific needs of the service user and/or their carers.

If for any reason it becomes clear during the initial discussion that the service user would prefer to speak to a different health and social care professional, the service user's wishes should be respected. A substitute with whom the service user is satisfied should be provided.

Use of a substitute health and social care professional for the 'Being Open' discussion

In exceptional circumstances, if the '*Being Open'* coordinator, who usually leads the discussion, cannot attend, they may delegate to an appropriately trained substitute. The qualifications, training and scope of responsibility of this person should be clearly delineated.

Assistance with the initial 'Being Open' discussion

The health and social care professional communicating information about a service user safety incident should be able to nominate a colleague to assist them with the meeting. Ideally this should be someone with experience or training in communication and '*Being Open'* procedures.

Responsibilities of junior health and social care professionals

Junior staff or those in training should not lead the '*Being Open'* process except when all of the following criteria have been considered:

- the incident resulted in insignificant or minor harm;
- they have expressed a wish to be involved in the discussions;
- the senior health and social care professional responsible for the care is present for support;
- the service user and/or their carers agree to their involvement.

Where a junior health and social care professional who has been involved in a service user safety incident asks to be involved in the '*Being Open'* discussion, it is important they are accompanied and supported by a senior team member. It is unacceptable for junior staff to communicate service user safety information alone or to be delegated the responsibility to lead a '*Being Open'* discussion unless they volunteer and their involvement takes place in appropriate circumstances (i.e. they have received appropriate training and mentorship for this role).

Service user safety incidents related to the environment of care

In such cases a senior manager of the relevant service will be responsible for communicating with the service user and/or their carers. A senior member of the multidisciplinary team should be present to assist at the initial '*Being Open'* discussion. The health and social care professional responsible for treating the injury should also be present to assist in providing information on what will happen next and the likely effects of the injury.

Involvement of health and social care staff who made the mistake

Some service user safety incidents result from errors made by the health and social care staff caring for the service user. In these circumstances the member(s) of staff involved may or may not wish to participate in the '*Being Open'* discussion with the service user and/or their carers. Every case where an error has occurred needs to be considered individually, balancing the needs of the service user and/or their carers with those of the health and social care professional concerned.

In cases where the health and social care professional that has made an error wishes to attend the discussion to apologise personally, they should feel supported by their colleagues throughout the meeting and should be made aware of staff representation organization support.

In cases where the service user and/or their carers express a preference for the health and social care professional not to be present, it is advised that a personal written apology is handed to the service user and/or their carers during the first '*Being Open'* discussion.

STAGE IV: INITIAL 'BEING OPEN' DISCUSSION

Content of the initial 'Being Open' discussion

The service user and/or their carers should be advised of the identity and role of all people attending the '*Being Open'* discussion before it takes place. This allows them the opportunity to state their own preferences about which health and social care staff should be present.

The content of the initial '*Being Open'* discussion with the service user, their family and carers should cover the following:

- An expression of genuine sympathy, regret and an apology for the harm that has occurred;

- The facts that are known are agreed by the multidisciplinary team. Where there is disagreement, communication about these events should be deferred until after the investigation has been completed;

- The service user, their family and/or their carers:

    - should be informed that an incident investigation is being carried out;
    - understanding of what happened is taken into consideration, as well as any questions they may have;
    - provided with information on the complaints procedure if they wish to have it;

- Consideration and formal noting of the service user's, their family's and carers' views and concerns, and demonstration that these are being heard and taken seriously;

- Service user's account of the events leading up to the service user safety incident are fed into the incident investigation for example, through Root Cause Analysis (RCA) whenever applicable;

- Provide carers and those very close to the service user with access to information to assist in making decisions if the service user is unable to participate in decision-making or if the service user has died as a result of an incident. This should be done with due regard to confidentiality and in accordance with the service user's instructions;

- Ensure carers are provided with known information, care and support if a service user has died as a result of a service user safety incident. The carers should also be referred to the coroner for more detailed information;

- Discussions with service users and/or their carers are documented and that information is shared with them;

- Appropriate language and terminology are used when speaking to service users, their families and carers;

- Assurance that an ongoing care plan will be developed in consultation with the service user and will be followed through followed by an explanation about what will happen next in terms of the short through to long-term treatment plan and incident analysis findings.

- Assurance that the service user will continue to be treated according to their clinical needs and that the prospect of, or an actual dispute between, the service user and/or their carers and the health and social care team will not affect their access to treatment;

- Information on likely short and long-term effects of the incident (if known). The long-term effects may have to be presented at a subsequent meeting when more is known;

- An offer of practical and emotional support for the service user, their family and carers. This may involve getting help from third parties such as charities and voluntary organisations, as well as offering more direct assistance. Information about the service user and the incident should not normally be disclosed to third parties without consent.

STAGE V: FOLLOW UP DISCUSSIONS

Follow-up discussions with the service user, their family and carers are an important step in the *'Being Open'* process – there may be more than one:

- The discussion(s) should occur at the earliest practical opportunity;
- Consideration should be given to the location and timing of meeting, based on both the service user's health and personal circumstances;
- Feedback should be given on progress to date and information provided on the investigation process;
- Repeated opportunities should be offered to the service user and/or their carers to obtain information about the service user safety incident;
- There should be no speculation or attribution of blame. Similarly, the health and social care professional communicating the incident must not criticise or comment on matters outside their own experience. Tell the service user and family what happened. Tell *what* happened now; leave details of *how* and *why* to later i.e. Stage V;
- The service user and/or their carers should be offered an opportunity to discuss the situation with another relevant professional where appropriate;
- A written record of the discussion should be kept and shared with the service user and/or their carers;
- All queries should be responded to appropriately;
- If completing the process at this point, the service user and/or their carers should be asked if they are satisfied with the investigation and a note of this made in the service user's records;
- The service user should be provided with contact details so that if further issues arise later there is a conduit back to the relevant health and social care professionals.

STAGE VI: PROCESS COMPLETION

Communication with the service user, their family and carers

After completion of the incident investigation, feedback should take the form most acceptable to the service user. Whatever method is used, the communication should include:

- the chronology of clinical and other relevant facts including an explanation of details of *how* and *why;*
- details of the service user's, their family's and carers' concerns and complaints;
- a repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the service user safety incident;
- 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;
- an ongoing clinical management plan. This may be encompassed in discharge planning policies addressed to designated individuals e.g. GP;
- reassurance that they will continue to be treated according to their clinical needs, even in circumstances where there is a dispute between them and the health and social care team. They should also be informed that they have the right to continue their treatment elsewhere if they prefer.

It is expected that in most cases there will be a complete discussion of the findings of the investigation and analysis. In some cases information may be withheld or restricted, for example, where communicating information will adversely affect the health of the service user; where investigations are pending coronial processes; or where specific legal requirements preclude disclosure for specific purposes. In these cases the service user will be informed of the reasons for the restrictions.

Communication with the GP and other community care service providers

In certain circumstances, it may be prudent to communicate with the service user's GP, before discharge, describing what happened. When the service user leaves the Trust, the discharge letter should also be forwarded to the GP or appropriate community care service. It should contain summary details of:

- the nature of the service user safety incident and the continuing care and treatment;
- the current condition of the service user;
- key investigations that have been carried out to establish the service user's clinical condition;
- recent results;
- prognosis.

DOCUMENTATION

Throughout the *Being Open* process it is important to record discussions with the service user, their family and carers as well as the incident investigation.

Written records of the '*Being Open'* discussions should consist of:

- the time, place and date, as well as the name and relationships of all attendees;
- the plan for providing further information to the service user, their family and carers;

- offers of assistance and the service user's, their family's and carers' response;
- questions raised by the service user, their family and carers, and the answers given;
- plans for follow-up meetings;
- progress notes relating to the clinical situation and an accurate summary of all the points explained to the service user, their family and carers;
- copies of letters sent to the service user, their family and carers, and the GP;
- copies of any statements taken in relation to the service user safety incident;
- a copy of the incident report.

The above detail should be recorded in the patient's notes and a summary of the Contact with service user /family regarding all incidents should be recorded in Datix Web against the incident record in the action taken field.

APPENDIX 5 – Being Open in Particular Circumstances

The approach to being open may need to be modified according to the service user's personal circumstances. The following gives guidance on how to manage different categories of service user circumstance.

When a service user dies

When a service user safety incident has resulted in a service user'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 and to involve them in deciding when it is appropriate to discuss what has happened. The service user'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.

"it may be appropriate to wait for the coroner's inquest before holding the '*Being Open'* discussion"

Usually, the 'Being Open' discussion and any investigation occur before the coroner's inquest. In certain circumstances the Trust may consider it appropriate to wait for the coroner's inquest before holding the 'Being Open' discussion with the service user'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 service user's death. In any event, an apology should be issued as soon as possible after the service user'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

When a child reaches 16 years they acquire 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.

Children younger than 16 years who understand fully what is involved in the proposed procedure can also give consent (Frazer competent). 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 after a service user safety 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.

Service users with mental health issues

'Being Open' for service users with mental health issues should follow standard procedures, unless the service user also has cognitive impairment (see below). The only circumstances in which it is appropriate to withhold service user safety incident information from a mentally ill service user is when advised to do so by a consultant psychiatrist who feels it would cause adverse psychological harm to the service user. However, such circumstances are rare and a second opinion (by another consultant psychiatrist) would be needed to justify withholding information from the service user. Except where exceptional circumstances prevail, it is inappropriate to discuss service user safety incident information with a carer or relative without

the express permission of the service user; to do so may constitute an infringement of the service user's Human Rights and/or a breach of Data Protection legislative provisions.

Service users with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them. They may have authorized 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 service user. The '*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 service user's best interests in deciding who the appropriate person is to discuss incident information with, regarding the welfare of the service user as a whole and not simply their medical interests. However, the service user with a cognitive impairment should, where possible, be involved directly in communications about what has happened. An advocate with appropriate skills should be available to the service user to assist in the communication process.

Service users with learning disabilities

Where a service user has difficulties in expressing their opinion verbally, an assessment should be made about whether they are also cognitively impaired (see above). If the service user is not cognitively impaired they should be supported in the '*Being Open'* process by alternative communication methods (e.g. given the opportunity to write questions down). An advocate, agreed on in consultation with the service user, should be appointed. Appropriate advocates may include carers, family or friends of the service user. The advocate should assist the service user during the '*Being Open'* process, focusing on ensuring that the service user's views are considered and discussed.

Service users with different language or cultural considerations

Reference must be made to the interpreting protocol when booking interpreters.

Service users with different communication needs

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

Service users who do not agree with the information provided

Sometimes, despite the best efforts of health and social care staff or others, the relationship between the service user and/or their carers and the health and social care professional breaks down. They may not accept the information provided or may not wish to participate in the '*Being Open'* process. In this case the following strategies may assist to deal with the issue as soon as it emerges:

- Where the service user agrees, ensure their carers are involved in discussions from the beginning;
- Ensure the service user has access to support services;
- Where the senior health professional is aware of the relationship difficulties, provide mechanisms for communicating information, such as the service user expressing their concerns to other members of the clinical team;
- Offer the service user and/or their carers another contact person with whom they may feel more comfortable. This could be another member of the team or the individual with overall responsibility for clinical risk management;

- Use a mutually acceptable mediator to help identify the issues between the health and social care organisation and the service user, and to look for a mutually agreeable solution;
- Ensure the service user and/or their carers are fully aware of the formal complaints procedures;
- Write a comprehensive list of the points that the service user and/or their carer disagree with and reassure them you will follow up these issues.

APPENDIX 6 – NPSA 'Being Open' safety alert November 2009

Alert

Patient Safety Alert

NPSA/2009/PSA003
19 November 2009

NHS
National Patient Safety Agency

National Reporting and Learning Service

Being Open

Communicating with patients, their families and carers following a patient safety incident

Being open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident in which the patient was harmed.

Being open supports a culture of openness, honesty and transparency, and includes apologising and explaining what happened.

In 2005, the National Patient Safety Agency (NPSA) issued a Safer Practice Notice advising the NHS to develop a local *Being open* policy and to raise awareness of this policy with all healthcare staff.

The guidance has now been revised in response to changes in the healthcare environment and in order to strengthen *Being open* throughout the NHS.

The revised *Being open* framework (available at **www.nrls.npsa.nhs.uk/beingopen**) should be used in conjunction with this Alert to help develop and embed *Being open* in each NHS organisation.

The *Being open* principles are fully supported by a wide range of royal colleges and professional organisations, including the Medical Defence Union, Medical Protection Society, NHS Litigation Authority and Welsh Risk Pool.

Tools to support organisations in the implementation of this Alert are available at: **www.nrls.npsa.nhs.uk/beingopen**

Endorsed by:

Action Against Medical Accidents
Department of Health
Healthcare Inspectorate Wales
NHS Confederation (England)
NHS Confederation (Wales)
NHS Litigation Authority
Medical Defence Union
Medical Protection Society
Royal College of General Practitioners
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians
Royal College of Psychiatrists
Welsh Assembly Government
Welsh Risk Pool

Action for the NHS

For action by Chief Executives of organisations commissioning and providing healthcare.

Deadlines:

- Actions underway: **22 February 2010**
- Actions completed: **23 November 2010**

Actions:

1) **Local policy:** Review and strengthen local policies to ensure they are aligned with the *Being open* framework and embedded with your risk management and clinical governance processes.
2) **Leadership:** Make a board-level public commitment to implementing the principles of *Being open*.
3) **Responsibilities:** Nominate executive and non-executive leads responsible for leading your local policy. These can be leads with existing responsibilities for clinical governance.
4) **Training and support:** Identify senior clinical counsellors who will mentor and support fellow clinicians. Develop and implement a strategy for training these staff and provide ongoing support.
5) **Visibility:** Raise awareness and understanding of the *Being open* principles and your local policy among staff, patients and the public, making information visible to all.
6) **Supporting patients:** Ensure Patient Advice and Liaison Services (PALS), and other staff have the information, skills and processes in place to support patients through the *Being open* process.

worth repeating...

This Alert replaces the *Being Open Safer Practice Notice* (2005)

NPSA Reference Number: NPSA/2009/PSA003
Gateway Reference: 13015
1097 November 2009

National Reporting and Learning Service
National Patient Safety Agency
4-8 Maple Street, London, W1T 5HD
T: 020 7927 9500 F: 020 7927 9501
www.nrls.npsa.nhs.uk

APPENDIX 7 – Guidance on issuing an apology – NI Ombudsman

Northern Ireland Public Services Ombudsman

GUIDANCE ON ISSUING AN APOLOGY

When the Ombudsman investigates a complaint and finds maladministration, she may recommend that the public service provider offers an apology. In these circumstances the complainant may have been waiting a considerable period of time for the organisation to provide a full explanation as to what went wrong and to acknowledge any failings.

What is an apology?

An apology can be defined as a 'regretful acknowledgement of an offence or failure'. Mistakes can be made by one member of staff, a whole team or there may be systemic failures within an organisation. When things do go wrong, most people who have had a bad experience may simply seek an acknowledgement and, if appropriate, to be given an explanation and an apology.

Why apologise?

In many cases an apology and explanation may be a sufficient and appropriate response to a complaint. The value of this approach should not be underestimated. A prompt acknowledgement and apology, where appropriate, can often prevent the complaint escalating. It can help restore dignity and trust in the public service provider and can be the first step in putting things right.

What are the implications of an apology?

Although there is no legislation in this area of law which applies specifically to Northern Ireland, the Compensation Act 2006 governing England and Wales states that 'an apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or statutory duty.' The timely provision of a full apology may in fact reduce the chances of litigation.

What is a meaningful apology?

Each complaint is unique so your apology will need to be based on the individual circumstances. It is important when you are making an apology, you understand how and why the person making the complaint believes they were failed and what they want in order to put things right. Failing to acknowledge the complainant's whole experience is only a partial apology and therefore less effective.

To make an apology meaningful you should:

- Accept you have done wrong. You should include identifying the failure along with a description of the relevant action or omission to which the apology applies. This should include any failings that the Ombudsman identified in her investigation that warrant an apology. Your description must be specific to show that you understand the effect your act

or omission has had on the complainant. It must also acknowledge if appropriate, that the affected person has suffered disappointment, hurt, anxiety, upset or loss;
- Clearly explain why the failure happened and include that the failure was not intentional or personal. If there is no explanation, however, one should not be offered. Care should be taken to provide full explanations rather than excuses;
- Demonstrate that you are sincerely sorry. An apology should be an expression of sorrow or at the very least an expression of regret. The nature of the harm done will determine whether the expression of regret should be made in person as well as being reinforced in writing; or simply in writing;
- Reassure the complainant that you will not repeat the failure. This may include a statement of the steps that have been taken, or will be taken, to address the failure, and, if possible, to prevent a reoccurrence;
- Provide the complainant with a statement of specific steps proposed to address the grievance or problem, by mitigating the harm or offering a remedy.

How should I make an apology?

There is no 'one size fits all' apology but the following points reflect some general good practice:

1. The timing of an apology is very important. Once you establish that you have done wrong, apologise. If you delay, you may lose your opportunity to apologise.

2. The language you use should be clear, plain and direct.

3. Your apology should not be conditional by qualifying the apology by saying for example: 'I apologise if you feel that the service provided to you was not acceptable' or 'if mistakes have been made, I apologise'.

4. To make an apology meaningful, do not distance yourself from the apology.

   Generalised apologies such as 'I am sorry for what occurred' or 'mistakes were made' do not sound natural or sincere. It is much better to accept responsibility by stating 'It was my fault'.

5. Avoid enforced apologies such as 'I have received the Investigation report from the Ombudsman and am therefore carrying out her recommendations by apologising to you for the shortcomings identified in her report.'

6. It is also very important to apologise to the right person or the right people.

Who should apologise?

If, in her Investigation report, the Ombudsman has made a recommendation that an apology should be provided to the complainant, then we would expect to see the Chief Executive, Director or Head of Department of the public service provider involved making the apology.

Who should receive the apology?

The apology should be sent directly to the complainant who is named in the Ombudsman's Investigation report. We will not, as a matter of course, review apologies prior to them being issued. However, in order to monitor compliance with the Ombudsman's recommendations, we would expect to receive a copy of the apology letter within the time required by the Ombudsman.

The benefits to organisations of apologising

It is important to remember that an apology is not a sign of weakness or an encouragement to take legal action. An apology can be a sign of confidence and competence and demonstrates a willingness to learn from mistakes and a commitment to put things right. To apologise in a fulsome and timely manner is good administrative practice and is an important part of effectively managing complaints.

Contact Details

You can contact us in the following ways:

Freepost:	Freepost NIPSO
or	The Northern Ireland Public Services Ombudsman
	Progressive House
	33 Wellington Place
	BELFAST
	BT1 6HN
Telephone:	028 9023 3821 **or Freephone:** 0800 34 34 24
Text Phone:	028 9089 7789
Email:	nipso@nipso.org.uk
or	By calling, 9.00am & 5.00pm, Monday to Friday, at the above address.

June 2016

APPENDIX 8 – Inquiry Reports relating to Duty of Candour

Miscellaneous Inquiry Recommendations Relating to Being Open and a Duty of Candour

The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report) (Feb, 2013)

In 2013, Robert Francis QC published the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Of the 290 recommendations detailed in the report, 12 were related to a requirement for 'openness, transparency and candour'.

These were defined as:

- Openness: enabling concerns to be raised and disclosed freely without fear, and for questions to be answered;
- Transparency: allowing true information about performance and outcomes to be shared with staff, service users and the public;
- Candour: ensuring that service users harmed by a health and social care service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it.

Recommendation 180 of the report reads 'Guidance and policies should be reviewed to ensure that they will lead to compliance with *Being Open*, the guidance published by the National Patient Safety Agency'.

Right time, right Place (Donaldson Report) (2014)

On 8 April 2014 former Health Minister Edwin Poots announced his intention to commission former Chief Medical Officer of England, Professor Sir Liam Donaldson, to advise on the improvement of governance arrangements across the HSC. This was subsequently published in January 2015 by his successor, Jim Wells.

Amongst the recommendation within this was that there should be the introduction of a Duty of Candour, in Northern Ireland in line with the *Making Amends* that examined the handling of complaints, incidents and medical negligence claims in a whole systems manner for England.

The Review Team considered that priority in Northern Ireland should be given to the areas covered by its recommendations and this included:

"a duty of candour should be introduced in Northern Ireland consistent with similar action in other parts of the United Kingdom"

Furthermore he suggested that:

".In Northern Ireland, it is already a requirement to disclose to service users if their care has been the subject of a Serious Adverse Incident report. There is no similar requirement for adverse incidents that do not cause the more severe degrees of harm. In promoting a culture of openness, there would be considerable advantages in Northern Ireland taking a lead and introducing an organisational duty of candour to match the duty that doctors and nurses are likely to come under from their professional regulators."

p36, § **4.5.3 Duty of candour**

Inquiry into Hyponatraemia-related Deaths (O'Hara) (2018)

The Inquiry into Hyponatraemia-related deaths in Northern Ireland was established in 2004 and chaired by Lord Justice O'Hara. His report, published in 2018, found that there had been significant failings both in the care of five children in Northern Ireland's hospitals, leading to their deaths, and in the subsequent dealings with their families.

Amongst the many recommendations in the report were those relating to the issue of candour and openness.

Candour

1. A statutory duty of candour should now be enacted in Northern Ireland so that:

    i. Every health and social care organisation **and** everyone working for them must be open and honest in all their dealings with service users and the public;
    ii. Where death or serious harm has been or may have been caused to a service user by an act or omission of the organisation or its staff, the service user (or duly authorised representative) should be informed of the incident and given a full and honest explanation of the circumstances;
    iii. Full and honest answers must be given to any question reasonably asked about treatment by a service user (or duly authorised representative);
    iv. Any statement made to a regulator or other individual acting pursuant to statutory duty must be truthful and not misleading by omission;
    v. Any public statement made by a health and social care organisation about its performance must be truthful and not misleading by omission;
    vi. Health and social care organisations who believe or suspect that treatment or care provided by it, has caused death or serious injury to a service user, must inform that service user (or duly authorised representative) as soon as is practicable and provide a full and honest explanation of the circumstances;
    vii. Registered clinicians and other registered health and social care professionals, who believe or suspect that treatment or care provided to a service user by or on behalf of any health and social care organisation by which they are employed has caused death or serious injury to the service user, must report their belief or suspicion to their employer as soon as is reasonably practicable.

2. Criminal liability should attach to breach of this duty and criminal liability should attach to obstruction of another in the performance of this duty.

3. Unequivocal guidance should be issued by the Department to all Trusts and their legal advisors detailing what is expected of Trusts in order to meet the statutory duty.

4. Trusts should ensure that all health and social care professionals are made fully aware of the importance, meaning and implications of the duty of candour and its critical role in the provision of health and social care.

5. Trusts should review their contracts of employment, policies and guidance to ensure that, where relevant, they include and are consistent with the duty of candour.

6. Support and protection should be given to those who properly fulfil their duty of candour.

7. Trusts should monitor compliance and take disciplinary action against breach.

8. Regulation and Quality Improvement Authority ('RQIA') should review overall compliance and consideration should be given to granting it the power to prosecute in cases of serial non-compliance or serious and wilful deception.