

THE DUTY OF CANDOUR POLICY AND PROCEDURES

Document Control

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Purpose

The publication of the Francis Inquiry report in 2013 instigated many changes in how we deliver health care and the way we work. In 2014 the Department of Health published the 'Hard Truths' report. Both reports reference the priority to make sure that people have the confidence that they will be given the best and safest care. As a result of the Francis Inquiry, A 'statutory duty of candour' came into being for England from October 2014. It is now a requirement within the NHSE Standard Contract. Providers and commissioners must;

- acknowledge, apologise and explain when things go wrong;
- conduct a thorough investigation into the incident and reassure service users, their families and carers that lessons learned will help prevent reoccurrence of the incident; and
- provide support for those involved to cope with the physical and psychological consequences of what happened.

In line with all the above, Barnardo's is committed to improving communication with service users and their families /carers when a service user is involved in an incident, and where this includes moderate harm, prolonged psychological harm, (non-permanent harm) severe harm (permanent harm) or

death. This also relates to those incidents that are retrospectively reported following identification via the claim process. Barnardo's will also ensure that service users, their carers / family, will be kept informed of the investigation and the outcomes.

If an incident is graded as no harm/near miss/low harm then the service user, families /carer should be informed of the incident in line with 'being open' principles, although this would not trigger the Duty of Candour. outlined below and that the incident will be investigated by a manager.

The Health and Social Care Act was updated in November 2014 to include the Duty of Candour regulation (regulation 20), which commenced for providers on 1st April 2015

Since November 2014 there has been a contractual requirement¹ by NHS Trusts to ensure compliance with the Duty of Candour within the NHSE Standard Contract for those incidents that result in moderate or severe harm, or death (utilising the National Child Safety Agency (NPSA) definitions).

In interpreting Regulation 20, the Care Quality Commission (2015) has published guidance on how this will be regulated and inspected.

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

Candour – any service user harmed by the provision of a NHS Funded service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

Better conversations about risk and the potential harm are essential for fostering a culture of candour, both as a means of preparing service user / family, carer should something bad happen, and to encourage clinicians and healthcare organisations to do the right thing when errors occur (Dalton, Williams, March 2014).

It is important to remember that saying sorry is not an admission of liability and is the right thing to do.

Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

Being Open is a process rather than a one-off event. It is a process underpinned by ten principles promoted in the National Child Safety Agency (NPSA) publication 'Being Open: Communicating service user / family, carer safety incidents with service users, family/ their carers' (NPSA (2009)) which informs the rationale for improving communication between Barnardo's staff and service user / carer. The principles are summarised in Associated guidance and documents section of this policy.

Being open relies initially on staff and the rigorous reporting of service user, family / carer safety incidents. Barnardo's endorses the Francis Report Recommendation 173:

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

Therefore, staff who are concerned about the non-reporting or concealment of incidents, or about ongoing practices which present a serious risk to service user safety, are encouraged to raise their concerns under the Barnardo's [Whistleblowing Policy](#).

Being open means apologising and explaining what happened to a service user(s), family / carer(s) who have been involved in a service user safety event and the principles should apply to all untoward events.

¹ Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (located at http://www.legislation.gov.uk/ukdsi/2014/978011117613/pdfs/ukdsi_978011117613_en.pdf)

Scope

This policy is aimed at all Barnardo's staff working on NHS Contracted services or services that are registered with CQC. within Barnardo's and sets out the policy and procedure which is in place to support openness between all staff and children, young people, their families and carers, following a client safety incident. This Policy must be read and enacted in conjunction with Barnardo's [guidelines on reporting Serious Incidents](#).

There are some differences in how the Duty of Candour is implemented in England and Scotland and these will be highlighted within the policy and procedure. The Duty of Candour for Wales and Northern Ireland is under consideration and as yet (October 2018) there is no legislation to support its implementation. The principles of openness and transparency as embodied in the Duty of Candour are in line with our Basis and Values and should be implemented across the whole of Barnardo's but the legal requirements of the Duty of Candour will only apply to services delivering contracts funded by the NHS or those registered with the CQC.

Roles & Responsibilities

Barnardo's Board of Trustees has a duty of care, which includes taking necessary steps to safeguard and protect children. They will act in children's best interests and ensure that they take all reasonable steps to prevent any harm to them. Trustees also have duties to manage risk and to protect Barnardo's assets and reputation. Barnardo's Trustees are responsible for ensuring that those benefitting from, or working with the organisation are not harmed in any way through contact with it.

Barnardo's Chief Executive The Chief Executive is ultimately Accountable for ensuring that incidents and complaints are effectively reported, an acknowledgement, apology and explanation is provided to those involved. The incident is investigated and associated learning embedded across Barnardo's services.

Directors and senior managers Directors and senior managers must ensure that communication and management systems are in place to enable front line staff to provide care as safely as possible in accordance with Barnardo's policies and procedures. Directors and senior managers have a responsibility to foster a culture of openness. They should ensure that staff are supported and have the confidence to report and acknowledge service user, family / carer safety events and provide an apology and explanation to service users and / or relevant others. Requirements in relation to training and opportunities for staff to undertake relevant Being Open training will be identified.

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

Children's Services and Business Lines Staff All Barnardo's staff delivering NHS Funded contracts or CQC registered services should familiarise themselves with the policy and understand the procedures for Being Open and Duty of Candour and follow the [guidelines on reporting Serious Incidents](#) where this is required.

Definitions

A complaint is an expression of dissatisfaction received by Barnardo's verbally or in writing either directly from or on behalf of service users, families and carers.

A claim is a request for compensation.

A service user safety incident is 'any unintended or unexpected incident that could have or did lead to harm for one or more service users receiving NHS funded healthcare'.

Notifiable Incidents

Regulation 20 defines what constitutes a notifiable safety incident for all providers and harm thresholds. The notifiable incidents that trigger the duty of candour for all providers are consistent with

existing definitions of notifiable incidents. Notifiable means that the service user, family / carer, or where appropriate their representative, must be notified of the incident. A notifiable incident refers to any unexpected or unintended incident that occurs where the care being given leads to, or is expected to lead to:

- the death of a service user, where the death relates directly to the incident rather than the natural course of the service users illness or condition
- severe harm, moderate harm or prolonged psychological harm

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

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

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

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

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

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

Relevant person This is the person who is receiving services or someone acting lawfully on their behalf in the following circumstances: on their death, or where they are under 16 and not competent to make a decision in relation to their care or treatment, or are 16 or over and lack the mental capacity in relation to the matter in accordance with the Mental Capacity Act 2005.

Written Notification A written notification is one given or sent to the relevant person in written form containing the information provided in any initial notification made in person, details of any enquiries to be undertaken, advise of any appropriate enquiries to be undertaken by the registered person, the results of any further enquiries into the incident, and an apology (as defined above).

DEFINITIONS AS SET OUT IN THE HEALTH (AND CARE) (SCOTLAND) ACT 2016 AND THE IMPLEMENTING REGULATIONS

"The **Act**" means the Health (Tobacco, Nicotine, etc. and Care) (Scotland) Act 2016.

"The **1978 Act**" means the National Health Service (Scotland) Act 1978.

"The **Regulations**" mean the Duty of Candour Procedure (Scotland) Regulations 2018.

" **care service**" has the meaning given by section 47(1) of the Public Services Reform (Scotland) Act 2010, except that it does not include a service mentioned in paragraph (k) of that section (child minding).

" **health service**" means services under the health service continued under section 1 of the 1978 Act, and an independent healthcare service mentioned in section 10F(1) of the 1978 Act.

"incident" means the unintended or unexpected incident by virtue of which section 21(2) of the Act applies to a person.

"the **procedure**" means the actions set out in regulations 2 to 7 of the Duty of Candour Procedure (Scotland) Regulations 2018.

"registered **health professional**" means a member of a profession to which section 60(2) of the Health Act 1999 applies.

"relevant **person, as set out in section 22(3) of the Act**" means the person who has received the health service, the care service or the social work service, or where that person has died, or is, in the opinion of the responsible person, lacking in capacity or otherwise unable to make decisions about the service provided, a person acting on behalf of that person.

"responsible **person**", as set out in section 25 of the Act, means:

- a Health Board constituted under section 2(1) of the 1978 Act;
- a person (other than an individual) who has entered into a contract, agreement or arrangement with a Health Board to provide a health service;
- the Common Services Agency for the Scottish Health Service constituted under section 10(1) of the 1978 Act;
- a person (other than an individual) providing an independent healthcare service mentioned in section 10F(1) of the 1978 Act;
- a local authority;
- a person (other than an individual) who provides a care service;
- an individual who provides a care service and who employs, or has otherwise made arrangements with, other persons to assist with the provision of that service (unless the assistance in providing that service is merely incidental to the carrying out of other activities);
- a person (other than an individual) who provides a social work service.
- "social **work services**" has the meaning given by section 48 of the Public Services Reform (Scotland) Act 2010.
- "written" includes electronic communication, as defined in section 15(1) of the Electronic Communications Act 2003.

Policy

1. Children and young people their families and carers have a right to expect openness from Barnardo's.
2. Barnardo's will learn from mistakes through full transparency and openness.
3. Barnardo's has a proactive approach to service user safety with the onus on all staff being open and transparent and working within Barnardo's' risk management systems and processes which will allow for the identification incidents which require review and learning.
4. Barnardo's will work in partnership with all stakeholders to ensure transparent learning
5. Staff do not intend to cause harm but unfortunately incidents do occur. When mistakes happen, service users, family / carers / others should receive an apology and explanation as soon as possible. **Saying sorry is not an admission of liability and staff should feel able to apologise at the earliest opportunity.**
6. Senior managers undertaking serious incident investigations must follow Barnardo's [guidelines on reporting Serious Incidents](#). They must ensure that appropriate support is offered to the service user / families / carers / others.
7. A single point of contact will be identified with the service user, family / carer / relative to maintain communication and feedback of information about the incident.

8. Line managers should understand that an individual or team may require support during the investigation and, after discussion, should guide them to the appropriate support mechanism. This will include contact details of both external and internal support. Ensure that staff involved with an investigation are aware of the support options available. Refer to B hive for information on 'Sources of Support' including the line manager, Local People Team, UNISON and Employee Assistance Programme.

Procedures

1. The detection and recognition of service user / carer safety events

Action: All Staff

1. The being open and duty of candour process begins with the recognition that a service user and / or relevant other has been involved in a service user, family / carer safety event. A service user, family/ carer safety event may be identified by:
 - a member of staff at the time of the incident;
 - a member of staff retrospectively when an unexpected outcome is detected;
 - a service user and / or relevant other who expresses concern or dissatisfaction with the service user's healthcare either at the time of the service user , family/ carer safety event or retrospectively;
 - incident detection systems such as incident reporting or medical records review;
 - other sources such as detection by other service users, visitors or non-clinical staff.

Action: Line Manager

1. As soon as a service user safety event is identified, the priority is to provide prompt and appropriate care and prevent further harm.
2. You must complete a [Serious Safeguarding Incident Form](#) within 24 hours and send it to your region/nation or departmental director and to all those on the circulation list detailed on the form.
3. If a current service user has died you must also complete the [Death of a Service User form](#) and send to all those on the circulation list detailed on the form.
4. If the incident also relates to Health and Safety, a [Barnardo's Incident Reporting Form](#) (BIRF) should be completed (see [guidelines on reporting Serious Incidents](#)).

Action: Head of Safeguarding/Senior Managers

1. Upon receipt of the [Serious Safeguarding Incident Form](#) which identifies an incident the Head of Safeguarding and key staff relevant to the incident will establish the facts of the case and to identify the timely and planned response to the service user and / or relevant others.

2. Duty Of Candour Process

Stage 1 Duty of Candour – within 10 working days of incident occurring

1. Within 10 working days of any moderate and above harm incident occurrence, or in the case of a reportable serious incident when it has been formally confirmed by the Head of Safeguarding an appropriate person, identified by the ADCS responsible for the managing the incident, must notify the

service user, family / carer / relative or person lawfully acting on their behalf that the incident has occurred.

2. Support should be provided and in cases of a high risk serious incident or complaint the ADCS will ensure liaison with the family throughout the Duty of Candour process.

3. The notification must:

Be conducted in person by the staff member responsible for the service user / carer or an agreed Barnardo's representative and include:

- An expression of genuine sympathy, regret and a meaningful apology² for the harm that has occurred.
- Current know facts about the incident (From the [Serious Safeguarding Incident Form](#))
- Explain that additional information may come to light as the investigation proceeds and that substantiated developments can be communicated
- Agree how the service user and/or carer would like to be kept informed (a meeting may be requested)
- Service users / carers must be reassured that access to treatment and the continuity of their care will continue accordingly to their clinical needs.
- They should be informed that they have the right to continue their treatment elsewhere if they prefer.

4. The Stage 1 Duty of Candour conversation must be clearly recorded in the service user's record, in line with the [Barnardo's Children's Services Recording Policy & Procedure](#) and on the [Serious Safeguarding Incident Form](#) .

5. A letter summarising the above discussion must be offered to the service user /carer and again this must contain a meaningful apology that expresses sorrow or regret at the occurrence of a service user / carer safety incident, along with details of the agreed process for providing updates to the service user / carer. The letter should also provide the details for a lead contact and enable a service user / carer to be able to raise specific questions that they may have around the incident. It may also be advantageous at this point to try and book a provisional date for sharing the findings of the investigation (if appropriate).

6. The date of the verbal discussion, name of the person who made the verbal contact and resultant letter sent, must be recorded on the [Serious Safeguarding Incident Form](#).

7. Letters must be saved in the service user record.

Stage 2 Duty of Candour – within 10 working days of investigation being approved by the Head of Safeguarding

1. The service user, family / carer must be offered a meeting to discuss the outcome of the incident investigation in to moderate incidents face to face within 10 working days of the investigation being approved by the Head of safeguarding. In the case of a serious incident, this will be within 10 working days of approval by the Head of Safeguarding, which adheres to the timescales outlined within the [guidelines on reporting Serious Incidents](#).

2. The service user, family / carer will be advised beforehand of the identity and role of all the Barnardo's officers who will be attending. This allows them the opportunity to ensure that they are

² **What is a meaningful apology?** An apology is often the first step in putting things right and can help to repair a damaged relationship and restore dignity and trust. To make an apology meaningful you should: 1. acknowledge what has gone wrong; 2. clearly describe what has gone wrong to show you understand what has happened and the impact for the person affected; 3. accept responsibility or the responsibility of your organisation for the harm done; 4. explain why the harm happened; 5. show that you are sincerely sorry; 6. assure the individual and/or their family of the steps you or your organisation have taken, or will be taking to make sure the harm does not happen again (where possible); 7. make amends and put things right where you can.

comfortable with all of the individuals that they will meet. Ensure that the service user, family / carers are offered support to meet their individual needs.

3. All questions (relating to the service user, family / carer safety incident) raised by the service user or family/carer as part of the initial notification should be addressed and if this is not possible (due to new questions arising), then agreement must be made in terms of when the answers to queries will be provided and by whom. The meeting must be followed up with a written letter and should include any further actions agreed. Any written notes of the meeting must be shared with all attendees for accuracy to be checked, after which they must be finalised, shared as the final draft and attached to the [Serious Safeguarding Incident Form](#).

4. In the event that the service user, family/ carer prefers not to meeting with Barnardo's officers to discuss the investigation findings, but wishes to receive a Stage 2 letter only and or the investigation report then this must be recorded on incident record. Plain English explanations of the content of the investigation should be provided and a list of abbreviations and/ or acronyms

5. Service Users who do not agree with the information provided. Sometimes, despite the best efforts of staff, the relationship between the service user, their family and carers and the staff member breaks down. They may not accept the information provided, may desire a higher level of investigation or may not wish to participate in the process. In this case, the following strategies may assist:

- where the service user, family / carer agrees, ensure their family and carers are involved in discussions from the beginning;
- write a comprehensive list of the points that the service user, their family and carers disagree with and reassure them you will follow up these issues.
- offer the service user, their family and carers another contact person with whom they may feel more comfortable. This could be another member of the team or a manager from another team or service;
- use a mutually acceptable mediator to help identify the issues between Barnardo's and the service user, family / carer to look for a mutually agreeable solution;
- ensure the service user, their family and carers are fully aware of the formal complaints procedures;

Children

5. The Head of Safeguarding can provide advice related to assessing and managing risks in relation to children and child protection, including information-sharing with other agencies. 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 (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 after an incident. The opportunity for parents to be involved should still be provided unless the child expresses a wish for them not to be present. Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents alone or in the presence of the child. In these instances the parents' views on the issue should be sought.

Mental Capacity

6. Central to any aspect of care delivered to adults and young people aged 16 years or over will be the consideration of the individuals capacity to participate in the decision making process. Consequently, no intervention should be carried out without either the individual's informed consent, or the powers included in a legal framework, or by order of the Court. Barnardo's policy on [Mental Capacity Act and DoLS](#) must be followed.
7. **Claims** Where a clinical negligence claim is brought following an act or omission that is alleged to have resulted in moderate, severe or catastrophic service user , family / carer harm, then Barnardo's will liaise with NHS Resolution with regards to how best to apply the principles of duty of candour.
8. **Scotland Only** If a relevant person mentions that they are considering making a claim, the duty of candour procedure should continue. If a relevant person makes a claim (i.e. Barnardo's receives formal notification of commencement of legal proceedings), then some elements of the duty of candour procedure may need to be paused until the legal process reaches a conclusion. For example, internal reviews could still proceed and organisations should still try to identify any potential improvement and learning actions.
9. The need for translation and advocacy services and consideration of special cultural needs must be taken into account when planning to discuss incident information. This could be achieved through obtaining advice from an advocate or translator before the meeting on the most sensitive way to discuss the information.
10. **Special circumstances** The approach to the Duty of Candour may need to be modified according to the service user, family/ carer personal circumstances. Where any modification conflicts with the Duty of Candour and poses a risk of a breach by Barnardo's, this must be escalated to the Head of Safeguarding for discussion with the Corporate Director.
11. Where compliance with duty of candour statutory timescales is affected by availability of service user / carer or lawful representative or appropriate interpreter this must be reported to the Head of Safeguarding prior to the breach occurring.

Task	By Whom	Action
Immediately the incident occurs or is identified		
Ensure the safety of those involved and the area	Children's services Manager	Review all children receiving care in the area / service to ensure they are safe.
Verbally report the incident to the ADCS	Children's services Manager	Report to the ADCS
Be Open and Transparent	ADCS for the service	Notify the service user, family / carer that incident has occurred
Report the incident in writing	Children's services Manager	Complete Serious Safeguarding Incident report form
Offer the service user, family/ carer support during and after the process	ADCS for the service	Identify appropriate support i.e. interpreters, advocates, counselling, self-help groups, transfer of care to another team
Within 10 Working Days the manager must		
Nominate a Lead to comply with the Duty	ADCS for service	Identify a lead who has not been involved in the service provision

of Candour		
Notify service user, family / carer that incident has occurred	Nominated lead. Staff should not attend being open discussions alone	1. In person 2. Include all known facts about the incident include an apology 3. Be delivered by a suitable manager from the service involved 4. Be followed by written notification 5. Be recorded in the Duty of Candour section of the Serious safeguarding incident form
Within 28 days of the Incident occurring or being identified		
Provide an explanation of the events and circumstances which resulted in the incident.	Duty of Candour Nominated lead	Provide and maintain written records of the interactions with the service user, family / carer or relevant person
Within 10 days of the investigation being complete		
Provide Feedback following the investigation into the incident	Duty of Candour Nominated lead	Meet with the relevant persons to discuss the findings of the investigation. Offer a meaningful apology. Be open and honest about the areas for learning and actions to be taken to prevent reoccurrence
Follow up in writing	Duty of Candour Nominated lead	Follow up the meeting in writing, confirming the findings and areas for learning /actions to be taken
Offer support to the service user/ family / carer	Duty of Candour Nominated lead	Counselling, self-help groups, transfer to another team and inform them of the complaints process.

Associated guidance and documents

The Ten Principles of Being Open

1. Principle of acknowledgement

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

2. Principle of truthfulness, timeliness and clarity of communication

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

3. Principle of apology

Service users and / or relevant others should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm that has resulted from a Child safety event. This should be in the form of an appropriately worded apology as early as possible. Both verbal and written

apologies should be given. Verbal apologies are essential because they allow face-to-face contact. A written apology, which clearly states the organisation, is sorry for the suffering and distress resulting from the Child safety event must also be given.

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

Service users and / or relevant others can reasonably expect to be fully informed of the issues surrounding a Child safety event, and its consequences, in a face-to-face meeting with representatives of Barnardo's. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times. Service users and / or relevant others should also be provided with support in a manner to meet their needs. This may involve an independent advocate or interpreter.

5. Principle of professional support

Staff must report Child safety incidents, see [Whistleblowing Policy](#). Details about the support staff is found on B Hive under Support for Staff. Where there is reason for Barnardo's to believe a member of staff has committed a punitive or criminal act, steps will be taken to preserve its position and advise the member of staff at an early stage to enable them to obtain separate legal advice and / or representation. These procedures must be followed in conjunction with [Barnardo's Disciplinary Procedures](#). Staff should be encouraged to seek support from relevant professional bodies.

6. Principle of risk management and systems improvement

Barnardo's uses systematic investigation techniques and tools to assist in uncovering the underlying causes of Child safety events. The investigation will focus on learning lessons and improving systems of care.

7. Principle of multi-disciplinary responsibility

The Being Open and Duty of Candour Policy applies to all staff responsible for the care of service users. Most healthcare provision involves multi-disciplinary teams and communication with service users and / or relevant others following a Child safety event should reflect this. This will ensure that the Being Open process is consistent with the philosophy that Child safety incidents usually result from system failures and rarely from the actions of an individual. Managers will champion the Being Open process to help ensure multidisciplinary involvement and the identification of staff who are able to undertake the role of the named point of contact for service users and / or relevant others.

8. Principle of quality governance

Being Open requires the support of Child safety and quality improvement through clinical governance frameworks to learn what can be done to prevent their recurrence. It also involves a system of accountability through the Chief Executive to Barnardo's Board of Trustees to ensure these changes are implemented and their effectiveness reviewed. These findings should be disseminated to staff so they can learn from Child safety incidents, see [guidelines on reporting Serious Incidents](#).

9. Principle of confidentiality

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

10. Principle of continuity of care

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

References

Dalton, Williams, March 2014 in DOH (2014) Introducing the Statutory Duty of Candour A consultation on proposals to introduce a new CQC registration regulation

Department of Health (2014) 'Hard Truths'. The Journey to putting Childs first

HMSO Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)

<https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour>

National Child Safety Agency (NPSA) publication 'Being Open: Communicating Child safety incidents with Childs and their carers' (NPSA (2009))

The Health and Social Care Act 2008

Compliance

Compliance with the policy will be monitored as part of the quality assurance work undertaken by the ADSC responsible for the service.

Document History

Version	Date	Author	Status	Comment
1	14/10/2018	Sarah Baker	draft	
2	13/11/18	Pat Greene	Approved	
3	5/6/20	Pat Greene	Policy reviewed	No amendments made

Sample Letter to inform the service user / carer of a duty of Candour incident

Date XXXX

Dear Service User / Carer (as appropriate)

You/Your (insert relative) have/has been involved in an incident..... describe event here.....

I wish to express my sincere apology that this event has occurred. Barnardo's aims to provide a quality service to you/your (relatives as appropriate) and to investigate promptly such incidents and share findings with those involved. To support anyone involved in an incident Barnardo's follows the Duty of Candour (Being Open) Policy, which lays out the actions we will be taking.

We would like to invite you/your (relatives as appropriate) to attend a meeting to provide a step-by-step explanation of the events and circumstances. Prior to this going ahead, I would appreciate your view on the following, in relation to this meeting.

- Your preference of time and date of meeting?
- Where would you wish to meet/proposed venue if there is any reason that this cannot be at the hospital or Health care centre?

If you wish to do so, please feel free to bring along a friend or relative to offer you support during this meeting. Also, if you wish, following the meeting you will be provided with further information relating to the outcome of the investigation.

If you would prefer not to attend any meetings please let us know.

When our investigation is completed we will write to you to provide feedback regarding the outcome.

I/ Staff member XXXXX is acting as your lead contact for the duration of the being open process. I/they can be contacted on telephone number xxxx xxxxxxxx

Yours sincerely

Date XXXX

Dear Service User, family / Carer insert appropriate inserting title & name)

You/Your (Insert relative) have/has been involved in an incident, which related to (brief description)on (date).

On behalf of Barnardo's and members of the team involved in the care of your son/ /daughter/father/mother, (insert name) please accept my sincere apology that this has occurred.

We aim to provide a quality service to service users and families, and to investigate incidents promptly and share findings with those involved.

To support anyone involved in an incident Barnardo's has a Duty of Candour (Being Open) policy. In line with this policy, you will be contacted by the investigating manager to discuss this with you. If you wish to talk about this beforehand, please do not hesitate to contact me on.....

When our investigation is complete you will be contacted with the findings.

Please be assured that it is not our intention to intrude upon you or your family at what may be a difficult time, however, it is important to keep you informed.

At this stage I/ Staff member XXXXX is acting as your lead contact for the duration of this process.

Yours sincerely

Letter of summary of the investigation findings

Date XXXX

Dear Service User, family / Carer (as appropriate inserting title & name)

As agreed following our initial letter dated, please find below a summary of the investigation findings into the incident/event/unexpected death of (name/relative) which happened on (date).

Description:

ENTER TEXT HERE

Immediate Action Taken:

ENTER TEXT HERE

Investigation findings:

ENTER TEXT HERE

Lessons Learned:

ENTER TEXT HERE

How these lessons learned will be shared across Barnardo's

ENTER TEXT HERE

I hope that this will help assure you that appropriate steps have been taken to identify the care and treatment issues relevant to the incident, and that recommendations for action have been prioritised.

Yours sincerely