Being Open Policy

**********Following paragraph not yet applicable**********

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Equality and Diversity Impact Assessment:	Completed and included in the document
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Target Audience:	All Staff

Contents

1 Introduction

1.1 This policy is based on guidance from the National Patient Safety Agency (NPSA), Being Open alert re-issued on the 19th November 2009. The alert encourages healthcare staff to apologise to patients harmed as a result of healthcare treatment and explains that an apology is not an admission of liability.

1.2 This policy is aimed at any healthcare staff responsible for ensuring the infrastructure is in place to support openness between staff and patients and/or their carers following a patient safety incident. It gives advice on the do's and don'ts of communicating with patients and/or their carers following harm. The Chief Medical Officer's consultation document, *Making Amends,* also outlines processes to encourage openness in the reporting of adverse events. This would encompass:

> 'a duty of candour requiring clinicians and health services managers to inform patients about actions which have resulted in harm'.

2 Purpose

2.1 The purpose of this document is to provide guidance to staff on their individual accountability in situations where a patient safety incident has occurred and direct them on action they should take to promote openness between staff and patients.

3 Scope

3.1 This policy applies to all employees of the Primary Care Trust (PCT), any staff who are seconded to the PCT, contracted and agency staff and any other individual working on PCT premises.

3.2 Although the PCT's Incident Reporting and Serious Untoward Incidents Policies requires staff to report all patient safety incidents, including those where there was no harm or it was a prevented patient safety incident (near miss), this policy only relates to those incidents where things have gone wrong and patients are harmed as a direct result. It is not a requirement that prevented Patient Safety incidents and 'no harm' incidents are discussed with patients.

4 Responsibilities

4.1 Chief Executive and Board

4.1.1 Overall accountability rests with the Chief Executive for the PCT. Compliance with this policy will be achieved by ensuring that there are systems in place to facilitate policy implementation. NHS Hull are committed to the principles of Being Open.

4.2 Managers

4.2.1 Managers are responsible for ensuring that the Being Open Policy is implemented when patient safety incidents occur.

4.3 Employee(s)

4.3.1 All employees have the responsibility to report all accidents/incidents, using the PCT's DATIX Incident Reporting Form and to inform their manager immediately if an accident/incident occurs that has resulted in the need for medical treatment, excessive injuries or any death of a patient.

5 Definitions

5.1 A "patient safety incident" is defined by the NPSA as an adverse event that involves a patient being harmed.

6 Equality and Diversity

6.1 The PCT is committed to:

- Eliminating discrimination and promoting equality and diversity in its Policies, Procedures and Guidelines, and
- Designing and implementing services, policies and measures that meet the diverse needs of its population and workforce, ensuring that no individual or group is disadvantaged.

6.2 To ensure the above, this Policy has been Equality Impact Assessed.

6.3 Details of the assessment are available on the PCT's website or by calling the PCT on (01482) 344700.

6.3 Where employees have difficulty expressing themselves, because of language or other difficulties, help should be sought from their Trade Union or other employee representatives or colleagues.

6.4 Consideration should be given to the provision of an interpreter or facilitator if there is understanding or language difficulties (perhaps a friend of the employee or colleague).

7 NHS Constitution

7.1 The PCT is committed to:

- the achievement of the principles, values, rights, pledges and responsibilities detailed in the NHS Constitution, and
- ensuring they are taken account of in the production of its Policies, Procedures and Guidelines.

7.2 This Policy supports the NHS Constitution and the NHS Pledge to provide support and opportunities for staff to maintain an open and supportive environment for patients and their families.

8 What does Being Open mean?

8.1 Being Open involves:

- acknowledging, apologising and explaining when things go wrong;
- conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring, and
- providing support for those involved to cope with the physical and psychological consequences of what happened.

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

8.3 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, Department of Health and NHS Litigation Authority.

8.4 The Care Quality Commission (CQC) guidance about compliance with the Section 20 Regulations of the Health and Social Care Act 2008 'A quality service, a quality experience' states, in relation to complaint handling, that service providers encourage and support a culture of openness that ensures any comments or complaints from service users, or others acting on their behalf, are listened to and acted upon.

8.5 The NPSA Seven steps to patient safety gives an overview for leaders of healthcare organisations on how to create an open and fair culture, and have in place appropriate processes that made improved openness between staff and patients a reality. Being Open relates directly to, and expands upon, Step 5: "Develop ways to communicate openly with and listen to patients".

8.6 Elements of the Being Open Policy are also related to other government initiatives and recommendations from major inquiry reports, including:

- recommendations in the 5th Shipman Inquiry Report about appropriate documentation of patient deaths, and
- the NHS Litigation Authority's *Striking the Balance* initiative on providing support for healthcare professionals involved in a complaint, incident or claim.

9. The Principles of Being Open

9.1 The NPSA identifies ten principles to Being Open:

9.1.1 ***1 Principle of acknowledgement***

All patient safety incidents should be acknowledged and reported as soon as they are identified on the Incident Reporting Form. The reportee's line manager and Director must be notified of incidents with moderate to severe harm and will nominate and support the appropriate staff member and patient with the Being Open process

2 Principle of truthfulness, timeliness and clarity of communication

Information about a patient safety incident must be given to patients and/or their carers in a truthful and open manner by an appropriately nominated person.

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3 Principle of apology

Patients and/or their carers should receive a sincere expression of sorrow or regret for the harm that has resulted from a patient safety incident. 'Saying sorry to patients and/or their carers is not an admission of liability'.

4 Principle of recognising patient and carer expectations

Patients should be fully informed of the issues surrounding a patient safety incident, and its consequences, in a face-to-face meeting with representatives from the healthcare organisation. Patients should also be provided with support in a manner appropriate to their needs. This involves consideration of special circumstances that can include a patient requiring additional support, such as an independent patient advocate or a translator.

5 Principle of professional support

All staff, whether directly employed or independent contractors, are encouraged to report patient safety incidents. The Hull PCT recognises that the taking of automatic punitive disciplinary action and inappropriate exclusion of staff from work following a patient safety incident will create a barrier to open reporting.

To facilitate systematic assessment of the actions of staff, and to determine the appropriate immediate action following a patient safety incident, staff should use the NPSA NRLS incident decision tree (IDT). It is designed for use by anyone who has the authority to exclude a member of staff from work following a patient safety incident.

Where concerns are identified about the performance of individual doctors, dentists or pharmacists the National Clinical Assessment Service (NCAS) can be contacted for advice on handling the concern and whether an assessment of the individual's practice would be helpful.

6 Principle of risk management and systems improvement

Incident investigation should focus on improving systems of care, which will then be reviewed for their effectiveness. The Hull PCT is committed to identifying the underlying causes of patient safety incidents, ie systems failures or latent conditions by using methods such as, Root Cause Analysis (RCA) and Significant Event Audit (SEA). Access to RCA and SEA training should be discussed with the Risk Team at Hull PCT.

7 Principle of multi-disciplinary responsibility

Any local policy on openness should apply to all staff who have key roles in the patient's care.

8 Principle of Clinical Governance

Being Open requires the support of the organisation's quality (risk management) processes for investigation and analysis of patient safety incidents, to find out what can be done to prevent their recurrence.

9 Principle of Confidentiality

Policies and procedures for Being Open should give full consideration of, and respect for, the patient's, their families and carers' and staff privacy and confidentiality in line with the CQC's guidance for Outcome 19. Details of a

patient safety incident should at all times be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the patient. Where this is not practical, or an individual refuses to consent to the disclosure, it 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 a clinical team should also be on the Caldicott principles need to know basis and, where practicable, records should be anonymous. It is good practice to inform the patient, their family and carers about who will be involved in the investigation before it takes place, and give them the opportunity to raise any objections.

10 Principle of Continuing Care

'Patients are entitled to expect that they will continue to receive all usual treatment and continue to be treated with respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made for them to receive treatment elsewhere.'

10 The Being Open Process

10.1.1 *Step 1: Incident is Identified*

Incident may be identified by patient, carer, PCT staff member or independent contractor. The DATIX web incident reporting form should be completed by notified staff member within 48 hours of the incident occurring. The line manager must be notified immediately as per the PCT's Incident Reporting Policy. Appendix A provides an explanation of those who should also be notified.

Step 2: Preliminary Team Discussion

The multi-disciplinary team, including the most senior health professional involved in the patient safety incident, should meet as soon as possible after the event to establish the facts and carry out an initial assessment to determine level of response. Appendix B should be used to grade the incident and determine the level of response.

Step 3: The Initial Being Open Discussion

The initial Being Open discussion is the first part of an ongoing communication process. The most senior person responsible for the patient's care and/or someone with experience and expertise in the type of incident should confirm to the patient/relative/carer that an incident has occurred and that this will be investigated. A copy of the incident reporting form should be shared with the patient. The initial Being Open discussion with the patient and/or their carers should occur as soon as possible after recognition of the patient safety incident. A verbal apology for any distress or harm should be offered at this point and should be recorded in the patient's notes. Factors to consider before holding this discussion include:

- Clinical condition of the patient. Some patients may require more than one meeting to ensure that all the information has been communicated to and understood by them;
- availability of key staff involved in the incident and in the Being Open process;
- availability of the patient's family and/or carers;

- availability of support staff, e.g. a translator or independent advocate, if required;
- patient preference (in terms of when and where the meeting takes place and who leads the discussion);
- privacy and comfort of the patient, and
- arranging the meeting in a sensitive location.

Step 4: Identify Support Needed by Patient/Relative/Carer/Staff

Patients/relatives/carers may need support from Patient advice & Liaison Service (PALS) or an independent patient advocate or translator at any stage throughout the process and the offer of information on access to these should be reiterated at regular intervals throughout the procedure. Healthcare staff should facilitate this process. A full comprehensive assessment of the patient's needs should be carried out. If a patient is incapacitated as a result of the incident and does not have relatives/carers to assist them, an independent representative should be assigned. The PALS manager may be an appropriate person to do this. Staff members involved in the incident may also be traumatised and if so, should be fully supported by their line manager. The Human Resources (HR) team and Occupational Health are additional sources of support if required. See Appendix C for a list of contacts.

Step 5: Incident Investigation

A multi-disciplinary investigation into the cause of the incident must be conducted in accordance with the PCT's Serious Untoward Incident and Incident Reporting Policy. This reflects the understanding that incidents usually result from system failures, rather than individual actions and ensures that all possible contributory factors are identified and taken into account. The level of the investigation will be dependent upon the seriousness and risk score of the incident. The procedure for determining the level of investigation required is fully explained in the PCT's Serious Untoward Incident and Incident Reporting Policy. The investigation should include the NPSA Root Cause Analysis methodologies.

Step 6: Documentation

The communication of patient safety incidents must be recorded. Required documentation includes:

- a copy of relevant medical information, which should be filed in the patient's medical records;
- incident reports, and
- records of the investigation and analysis process.

There should be documentation of:

- the time, place, date, as well as the name and relationships of all attendees;
- the plan for providing further information to the patient and/or their carers;
- offers of assistance and the patient's and/or carer's response;
- questions raised by the family and/or carers or their representatives and the answers given;
- plans for follow-up as discussed;
- progress notes relating to the clinical situation and an accurate summary of all the points explained to the patient and/or their carers;

- copies of letters sent to patients, carers and the GP for patient safety incidents not occurring within primary care;
- copies of any statements taken in relation to the patient safety incident, and
- a copy of the incident report.

Step 7: Updating Patients/Relatives/Carers on Progress with the Investigation

Patients/relatives/carers should be given regular updates on the progress of the investigation either verbally/written/or by further meetings, adhering to the principles in previous stages of this procedure. Before information is provided to the patient/relatives/carers, this should be confirmed by an appropriate senior member of staff involved in the investigation. The following guidelines should assist in making the communication effective:

- the discussion should occur at the earliest practical opportunity, once there is additional information to report;
- consideration should be given to the timing of the meeting, based on both the patient's health, personal circumstances and cultural needs;
- consideration should be given to the location of the meeting, e.g. The patient's home. Feedback should be given on progress to date and information provided on the investigation process;
- there should be no speculation or attribution of blame. Similarly, the healthcare professional communicating the incident must not criticise or comment on matters outside their own experience;
- the patient 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 patient and/or their carers;
- all queries should be responded to appropriately;
- if completing the process at this point, the patient and/or their carers should be asked if they are satisfied with the investigation and a note of this made in the patient's records, and
- the patient should be provided with contact details, so that if further issues arise later there is a conduit back to the relevant healthcare professionals or an agreed substitute.

Step 8: Completion of Being Open Procedure and Written Apology

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

- the chronology of clinical and other relevant facts;
- details of the patient's and/or their carer's concerns and complaints;
- a repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the patient 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. 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, e.g. where communicating information will adversely affect the health of the patient; where investigations are pending coronial processes or where

specific legal requirements preclude disclosure for specific purposes. In these cases the patient will be informed of the reasons for the restrictions, and

- The patient/relative/carer should be given the opportunity to respond to the outcome of the investigation and on the way the Being Open procedure was conducted. Any responses should be documented.

Step 9: Continuity of Care

Following an incident the patient should continue to receive all usual treatment and should continue to be treated with respect and compassion by PCT staff. Should the patient wish receive treatment from another healthcare team, arrangements should be made to facilitate this wish. Patients/relatives/carers should be reassured that the incident and its investigation will not impact upon the continuing treatment provided.

Step 10: Patients/Relatives/Carers not Satisfied with the Outcome

Should this occur, a mutually acceptable mediator should be arranged, eg the PALS Manager, to help identify areas of disagreement. Each point of disagreement should be addressed and a response provided in writing. The patient/relative/carer should also be informed of how to make a formal complaint, in accordance with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Step 11: Communication of changes to staff

Effective communication with staff is a vital step in ensuring that recommended changes are fully implemented and monitored. It will also facilitate the move towards increased awareness of patient safety issues and the value of Being Open. Team meetings, newsletters and the PCT web site are all available to help communicate with staff.

Step 12: Communication of Lessons Learned throughout the Health Service

The PCT feeds back all lessons learnt on patient safety incidents through the NPSA NRLS system. The NPSA will publish patient safety alerts, safer practice notices and patient safety information notices through the Central Alert Broadcast System to highlight common factors that cause patient safety incidents, and to publicise its advice and solutions to the service. The primary aim will be to help reduce the risk of such incidents recurring. It will also use its website, www.npsa.nhs.uk plus a number of specialist web resources, to share this and supporting background information with healthcare staff throughout the NHS.

11 Monitoring and Feedback

11.1 Any recommendations for systems improvements and changes implemented will be detailed in an action plan. This will be linked to the incident on the incident database. The progress, final completion of and effectiveness of the action plan will be monitored and reported to the relevant Committees. Examples of good practice will be passed to the NPSA for sharing with the rest of the NHS. The results of Being Open discussions with patients and/or carers will be reported via the incident reporting database by the manager leading the process. This will facilitate the analysis of the Being Open process.

12 Monitoring Compliance with and Effectiveness of this Policy

12.1 Monthly Safety Reports will be produced in which compliance will be reported and monitored. These will be shared with the appropriate committees.

12.2 This policy will be communicated through ad hoc risk management training sessions and will be made available on the PCT intranet.

12.3 Monitoring the effectiveness of this Policy will be conducted through staff surveys.

13 References

"Being Open", National Patient Safety Agency Alert November 2009
NPSA Seven Steps to Patient Safety for Primary Care
http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59804
Apologies and Explanations, NHS Litigation Authority (NHSLA) circular 02/02 (February 2002))
Good Medical Practice Guide, General Medical Council (2001)
Making Amends, Department of Health (2003)
NPSA Being Open Framework 19/11/2009
http://www.nrls.npsa.nhs.uk/resources/?entryid45=65077
NPSA Incident Decision Tree
http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59900
NPSA Root Cause Analysis Technique
https://report.npsa.nhs.uk/rcatoolkit/course/iindex.htm
Harold Shipman's clinical practice 1974-1998: a clinical audit commissioned by the Chief Medical Officer, Department of Health (2001)

14 Associated Documentation

14.1 This Policy should be read in conjunction with the following documents:

- Complaints Policy
- Serious Untoward Incident Policy and Procedure
- Incident Reporting Policy and Procedure
- Confidentiality Policy
- Making Experiences Count Policy
- Central Alerting System (CAS) Policy
- Caldicott & Data Protection Policy

15 Review

15.1 This Policy will be reviewed on an annual basis.

15.2 Minor amendments (such as changes in title) may be made prior to the formal review.

Appendix A

Notification Process

Risk Team

In all cases, the Risk Team should be informed either by telephone, electronically or by completion of the incident form. The NPSA will then receive anonymous notification of the incident through the National Reporting and Learning System.

Management

The individual who discovers the incident should report it through their Line Manager who notifies the Executive with the lead for patient safety. When a serious incident occurs (see Serious Untoward Incident Policy for definition) or where a criminal act is suspected, the Director or if out of hours, the on call manager must be notified immediately as per the reporting system detailed in the Serious Untoward Incident and Incident Reporting Policy.

General Practitioner

Consideration should be given to contacting the referring GP at an early time for incidents that have not occurred within primary care, but have implications for continuity of care. By informing them they can offer their support to the patient and/or their carers.

The Coroner

All cases of untimely, unexpected or unexplained death or suspected unnatural deaths need to be reported to the Coroner. A Coroner may request the case is not discussed with other parties until the facts have been considered. However, this should not preclude a verbal and written apology or expression of regret where appropriate. In this situation it should be made clear to the family that a full discussion of the circumstances and any residual concerns will be arranged at a date to suit both parties after the Coroner's assessment is finished.

It should also be recognised that Coroner investigations are stressful for patients, families, carers and staff. Bereavement counselling and advice on professional support groups should be offered at the outset of a Coroner's investigation. Appendix C gives contact details for various support groups.

Relevant Statutory/Other Bodies

The Serious Untoward Incident & Incident Reporting Policy details which external agencies should be informed of a patient safety incident and when this should occur. The Risk Team are responsible for notifying these relevant agencies, such as the Strategic Health Authority, National Health Service Litigation Authority or Health & Safety Executive (RIDDOR).

Appendix B

Grading of patient safety incidents to determine level of response

Incident	Level of Response
No harm (including prevented patient safety incident)	Patients are not usually contacted or involved in investigations and these types of incidents are outside the scope of the Being Open Policy. Individual healthcare organisations decide whether 'no harm' events, including prevented patient safety incidents are discussed with patients, their families and carers, depending on local circumstances and what is in the best interest of the patient.
Low harm	Unless there are specific indications or the patient 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. Reporting to the Risk Management team will occur through standard incident reporting mechanisms and be analysed centrally to detect high frequency events. The 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. Communication should take the form of an open discussion between the staff providing the patient's care and the patient, their family and carers. **Apply the principles of Being Open**
Moderate harm, severe harm or death	A higher level of response is required in these circumstances. The Risk Manager or equivalent should be notified immediately and be available to provide support and advice during the Being Opening process, if required. **Apply the Being Open process**

Appendix C

Support Groups

Find out more about local services at Patient UK – www.patient.co.uk

Complaints Advice & Advocacy

Advice

Hull PCT Patient Advice & Liaison Service
The Maltings
Silvester Square
Silvester Street
HULL
HU1 3HA

E-mail: h-pct.pals@nhs.net
Tel: 01482 335409

Advocacy

Independent Complaints Advocacy Service (ICAS)

E-mail: hullicas@carersfederation.co.uk
Tel: 0808 802 3000

Complaints second stage

The Parliamentary & Health Service Ombudsman
Millbank Tower
Millbank
London
SW1P 4QP

E-mail: phso.enquiries@ombudsman.org.uk
Tel: 0345 015 4033

National Organisations

The Child Bereavement Trust

Aston House
West Wycombe
High Wycombe
Bucks
HP14 3AG

Information and support service Tel line: 0845 357 1000
enquiries@childbereavement.org.uk

www.childbereavement.org.uk

National UK Charity providing specialised training and support for professionals to help them respond to the needs of bereaved families.

Resources and information for bereaved children and families as well as the doctors, nurses, midwives, teachers, police, emergency services and Voluntary Sector support services.

Cruse Bereavement Care

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

Tel: 0870 167 1677

www.crusebereavementcare.org.uk

This is a Charity that provides information to anyone who has been affected by a death. Also, this service offers education, support, information and publications to anyone supporting bereaved people. A National Charity with over 6,000 trained counsellors.

Supportline

PO Box 1596
Ilford
Essex
IG1 3FW

Helpline Tel: 020 8554 9004 (opening hours vary)

www.supportline.org.uk

A helpline that provides confidential, emotional support to children, young people and adults on any issue, which refers callers to sources of help in their immediate area.

London Bereavement Network

356 Holloway Road
London
N7 6PA

Tel: 020 7700 8134

www.bereavement.org.uk/about/index.asp

This service offers information and a referral service to anyone living in Greater London who is affected by bereavement.

British Association for Counselling & Psychotherapy

1 Regent Place
Rugby
Warwickshire
CV21 2PJ

Tel: 0870 443 5252

www.bacp.co.uk

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

Jewish Bereavement Counselling Service
PO Box 6748
London
N3 3BX

Tel: 020 8349 0839 or 020 8343 8989

www.jvisit.org.uk/jbcs/

The service is offered to any member of the Jewish community at no charge.

Royal College of Psychiatrists

www.rcpsych.ac.uk/info/help/bereav/

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

Depression Alliance

35 Westminster Bridge Road
London
SE1 7JB

Textphone/Minicom: 020 7928 9992

www.depressionalliance.org

A UK charity offering information to people with depression, which is run by sufferers.

Samaritans

Helpline Tel: 08457 90 90 90 (24 hours)

www.samaritans.org

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

If I Should Die

www.ifishoulddie.co.uk

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

Support for Carers

The Princess Royal Trust for Carers

142 Minories
London
EC3N 1LB

Tel: 020 7480 7788

www.carers.org

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

Carers UK/ Carers National Association

20-25 Glasshouse Yard
London
EC1A 4JS

Helpline Tel: 0808 808 7777 (a free phone number between 10am-12noon and 2 pm – 4 pm Mon-Fri)

www.carersuk.org.uk/about/main.htm

A helpline service that provides support in encouraging carers to recognise their own needs.

There is also an Information Officer to answer enquiries from professionals.

Caring Matters

132 Gloucester Place
London
NW1 6DT

Tel: 020 7402 270

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

Seniorline

England, Scotland, Wales
Tel: 0808 800 6565 (free phone)

Northern Ireland
Tel: 0808 808 7575 (free phone)

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

A free National information service for senior citizens, their carers and relatives.

When a baby or child dies

Child Death Helpline

Great Ormond Street Hospital for Children
London
WC1N 3JH

Tel: 0800 282 986

www.childdeathhelpline.org.uk

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

Compassionate Friends

53 North Street
Bedminster
Bristol
BS3 1EN

Help Line Tel: 0117 953 9639 (open seven days 9.30 am - 10.30 pm)

www.tcf.org.uk

This service provides support and friendship for bereaved parents and their families.

SANDS - Stillbirth and Neonatal Death Society (UK)

28 Portland Place
London
W1N 4DE

Helpline Tel: 0207 436 5881

www.uk-sands.org

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

The Cot Death Society

1 Browning Close
Thatcham
Berks
RG13 4AU

Tel: 01635 861 771

A service that provides help and support for anyone affected by cot death.

Scottish Cot Death Trust

Tel: 0141 357 3946

www.sidscotland.org.uk

This service provides support and information to parents bereaved by sudden infant deaths.

The Foundation for the Study of Infant Deaths

24-hour helpline Tel: 0207 235 1721

This service offers help to those who have lost a baby.

Babyloss.com

www.babyloss.com

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

Loss in Pregnancy

Miscarriage Association

Helpline Tel: 01924 200 799
Helpline (Scotland): 0131 331 883
www.miscarriageassociation.org.uk

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

Help for Young People

rd4u

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

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

www.rd4u.org.uk

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

Winston's Wish

The Clara Burgess Centre
Gloucestershire Royal Hospital
Great Western Road
Gloucester
GL1 3NN

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

www.winstonswish.org.uk

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

ChildLine

Helpline Tel: 0800 1111
www.ChildLine.org.uk

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

Childhood Bereavement Network

Huntingdon House
278 - 290 Huntingdon Street
Nottingham
NG1 3LY
Tel: 0115 911 8070

A new National resource for bereaved children and young people, their parents and care givers.

Special Circumstances

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

When a patient dies

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

Usually, the Being Open discussion and any investigation occur before the Coroner's inquest. But in certain circumstances, the healthcare organisation may consider it appropriate to wait for the Coroner's inquest before holding the Being Open discussion with the patient's family and/or carers. The Coroner's report on post-mortem findings is a key source of information that will help to complete the picture of events leading up to the patient's death. In any event an apology should be issued as soon as possible after the patient's death, together with an explanation that the Coroner's process has been initiated and a realistic timeframe of when the family and/or carers will be provided with more information.

Children

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

The courts have stated that younger children who understand fully what is involved in the proposed procedure can also give consent. This is sometimes known as Gillick competence or the Fraser guidelines. Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the Being Open process after a patient 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. More information can be found on the Department of Health's website: www.dh.gov.uk.

Patients with Mental Health Issues

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

Patients with Cognitive Impairment

Some individuals have conditions that limit their ability to understand what is happening to them. They may have authorised a person to act on their behalf by an enduring power of attorney. In these cases, steps must be taken to ensure this extends to decision making and to the medical care and treatment of the patient. The Being Open discussion would be held with the holder of the power of attorney. Where there is no such person, the clinicians may act in the patient's best interest in deciding who the appropriate person is to discuss incident information with, regarding the welfare of the patient as a whole and not simply their medical interests. However, the patient with a cognitive impairment should, where possible, be involved directly in communications about what has happened. An advocate with appropriate skills should be available to the patient to assist in the communication process.

Patients with Learning Disabilities

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

Patients who do not agree with the information provided

Sometimes, despite the best efforts of healthcare staff or others, the relationship between the patient and/or their carers and the healthcare 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:

- deal with the issue as soon as it emerges;
- where the patient agrees, ensure their carers are involved in discussions from the beginning;
- ensure the patient has access to support services;
- where the senior health professional is not aware of the relationship difficulties;
- provide mechanisms for communicating information, such as the patient expressing their concerns to other members of the clinical team;

- offer the patient and/or their carers another contact person with whom they may feel more comfortable. This could be another member of the team or the individual with overall responsibility for clinical risk management;
- use a mutually acceptable mediator to help identify the issues between the healthcare organisation and the patient, and to look for a mutually agreeable solution;
- ensure the patient and/or their carers are fully aware of the formal complaints procedures, and
- write a comprehensive list of the points that the patient and/or their carer disagree with and reassure them you will follow up these issues.

Patients with a different language or cultural considerations

The need for translation and advocacy services, and consideration of special cultural needs, such as (for patients from cultures that make it difficult for a woman to talk to a male about intimate issues), must be taken into account when planning to discuss patient safety incident information. It would be worthwhile to obtain advice from an advocate or translator before the meeting on the most sensitive way to discuss the information. Avoid using 'unofficial translators' and/or the patient's family or friends as they may distort information by editing what is communicated.

Patients with different communication needs

A number of patients will have particular communication difficulties, such as a hearing impairment. Plans for the meeting should fully consider these needs. Knowing how to enable or enhance communications with a patient is essential to facilitating an effective Being Open process. There should be a focus on the needs of individuals and their families, with thoughtful and respectful communication.

Appendix E

AUTHOR'S EQUALITY IMPACT ASSESSMENT

TITLE OF PPG: Being Open Policy

DATE: 31/5/2012

		Yes/No	Comments
1.	**Does the PPG affect one group less or more favourably than another on the basis of:**	No	
	• Race	no	
	• Ethnic origins (including gypsies and travellers)	no	
	• Nationality	no	
	• Gender	no	
	• Culture	no	
	• Religion or belief	no	
	• Sexual orientation including lesbian, gay and bisexual people	no	
	• Age	no	
	• Disability - learning disabilities, physical disability, sensory impairment, mental health problems and progressive conditions as stated in the Disability Discrimination Act 2005	no	
	• Trade Union Membership	no	
2.	**Is there any evidence that some groups are affected differently?**	Yes	Potentially affects individuals who need alternative language or format
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**	n/a	
4.	**Is the impact of the PPG likely to be negative?**	No	
5.	**If so can the impact be avoided?**	n/a	
6.	**What alternatives are there to achieving the PPG without the impact?**	n/a	
7.	**Can the impact be reduced by taking different action?**	n/a	

If you have identified a potential discriminatory impact of this document, please detail overleaf any suggestions as to the action required to avoid/reduce this impact.

Suggested Actions

PCT website and front pages of policy should contain wording in alternative languages on how to obtain information in alternative languages / formats

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Equality and Diversity Training last attended in (Month/Year): April 2011

For advice in respect of answering any of the questions, please contact the PCT Equality and Diversity Team on (01482) (34)4700.

Initial Screening by Equality and Diversity Officer:

Name of Officer: _____

Date of Initial Screening: ____/____/____

Comments:

Refer PPG on to Equality and Impact Assessment Panel? Yes/No