Positively Different

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

Learning Lessons Quarterly Bulletin

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Focus on Duty Of Candour

Welcome to South Staffordshire and Shropshire Healthcare NHS Foundation Trust's Learning Lessons bulletin.

As a Trust we recognise the benefits that can be had from sharing and cascading learning from incidents and near misses, and know that if this is done effectively it can help to minimise future risk and strengthen the quality of the services we provide.

The Trust is committed to quality improvement, and will continue its strong focus on delivering high quality, safe and effective services. This new quarterly bulletin is an important component of a number of key approaches embraced by the Trust to drive forward the quality agenda.

The ultimate aim of evaluating our services and learning lessons is to improve outcomes for service users. This bulletin is intended to support this aim by communicating and strengthening local and national lessons to be learnt from both positive practice and areas for improvement.

In this issue we have focused on the subject of Duty of Candour. We shall take a look at the legal obligations on us as an organisation and outline how all staff will be required to implement it.

We hope that you find this bulletin informative and useful and welcome your ideas and input into future issues.

Background to Duty of Candour

What is Duty of Candour?

From 27th November 2014 Duty of Candour becomes a legal requirement. It places a formal requirement on providers of health or social care to be open with their patients when they suffer harm related to care or treatment. It's aim is to ensure that openness, transparency and candour are the norm. While there is already a contractual duty of candour contained in NHS Standard Contracts, this new statutory duty will apply to a wider range of providers.

Responsibilities of all Trust Employees:

There is a statutory Duty of Candour on registered healthcare professionals to inform their employer where they believe or suspect that treatment has caused death or serious injury and; ; a criminal offence for any registered medical practitioner, or nurse or allied health professional or director of an authorised or registered healthcare organisation to knowingly obstruct another in the performance of these statutory duties, provide information to a patient or nearest relative with the intent to mislead them about such an incident or dishonestly make an untruthful statement to a commissioner or regulator, knowing or believing that they are likely to rely on the statement in the performance of their duties.

Learning Lessons Features

Duty of Candour

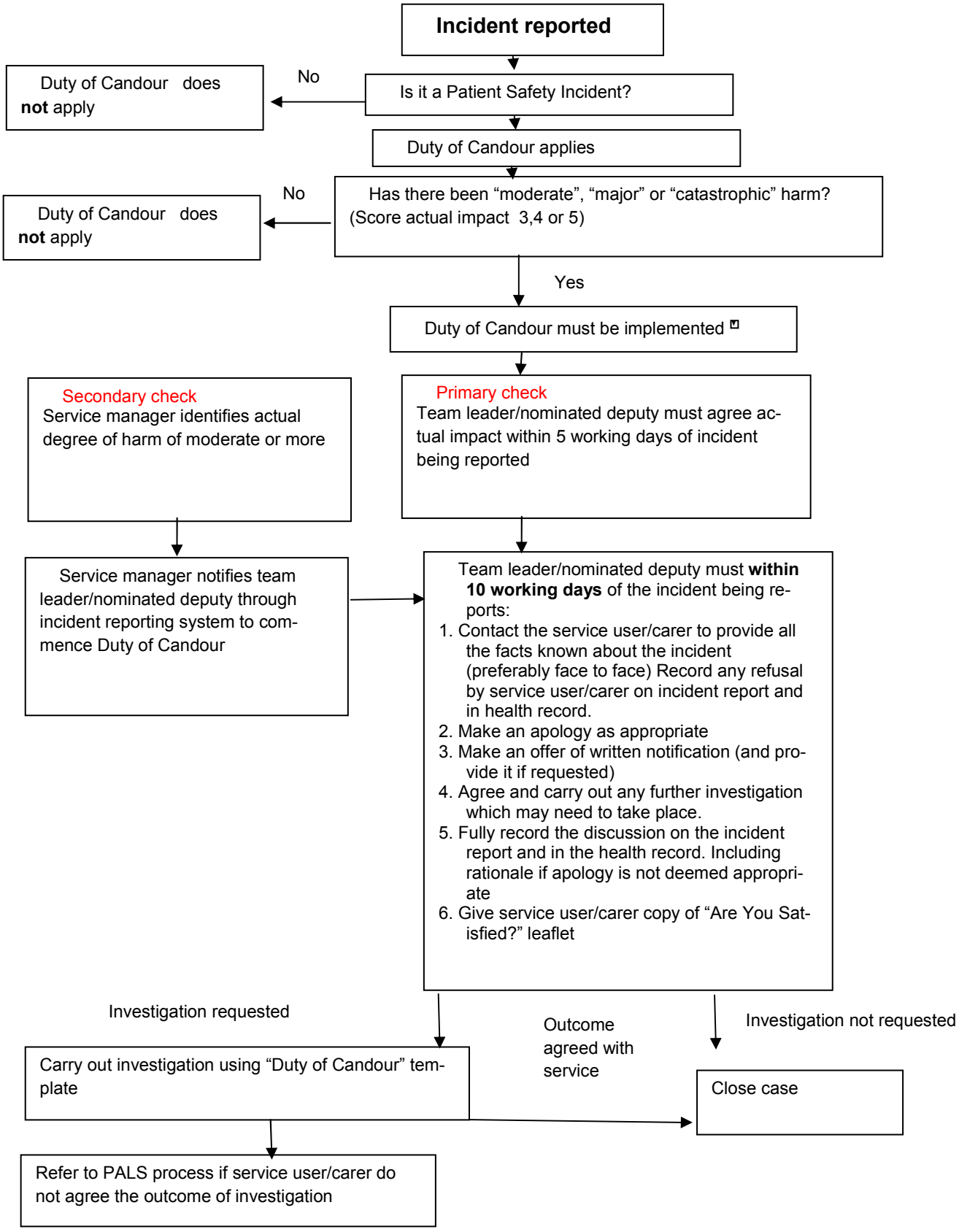
Duty of Candour is in place to ensure service users/their families are told about patient safety incidents that affect them, receive appropriate apologies and are kept informed of investigations and are supported to deal with the consequences.
Duty of Candour applies when all 3 criteria below are met:

1. Any **Patient Safety Incident** ie. any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care and
2. Scores 3 or higher on severity of the harm as per the table below:
3. This applies to the "**actual impact**" as opposed to the severity score on the risk matrix.

Duty of Candour applies to all patient safety incidents which result in moderate harm

Actual Im-pact	Category	Description
1	None/ insignifi-cant	No harm: **Impact prevented** – Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. **Impact not prevented** – Any patient safety incident that ran to completion but no harm occurred to people receiving NHS funded
2	Minor	**Low:** Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care. (Minor treatment= first aid, additional therapy, or additional medication. It does not include any extra stay in hospital or any extra time as an outpatient, or continued treatment over and above the treatment already planned. Nor does it include a return to surgery
3	Moderate	**Moderate:** Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care. (Moderate harm = Moderate increase in treatment is defined as a 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 area such as intensive care as a result of the incident. For example self-harm resulting in general
4	Major	**Severe:** Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care. (Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiologic or intellectual, including loss of limb, or brain damage for example as a result of self harm)
5	Catastro-phic	**Death:** Any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care. The death must relate to the incident rather than to the natural course of the patient's illness or underlying condition.

Learning Lessons Features– Process for Duty of Candour



CQC Regulation 20—Duty of Candour

This regulation applies to health service bodies only from 1 October 2014. It will be extended to all other providers from 1 April 2015, subject to Parliamentary process and approval.
The intention of this regulation is to ensure that providers are open and honest with service users and other 'relevant persons' (people acting lawfully on the behalf of service users) when things go wrong with care and treatment, and that they provide them with reasonable support, truthful information and a written apology.
To meet the requirements of this regulation, providers must ensure an open and honest culture exists across, and at all levels, within their organisation. The provider must ensure it has systems in place for knowing about notifiable safety incidents* and must tell the relevant person(s), in a timely manner, when such an incident has occurred. This includes providing a truthful account of the incident, providing an explanation in writing about the enquiries and investigations that will be undertaken and offering an apology in writing. In addition, the provider must maintain appropriate written records and offer reasonable support in relation to the incident.
*The regulation, provides an explanation of what is meant by 'notifiable safety incident', 'harm', and an 'apology'.
If a provider that aspires to be registered with CQC cannot demonstrate that it will meet the requirements of this regulation from its first day of business, CQC may refuse its application for registration.

Sign Up To Safety

In June 2014 NHS England launched "Sign up to safety". This a new campaign designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement. This ambition is bigger than any individual or organisation and achieving it requires us all to unite behind this common purpose. We need to give patients confidence that we are doing all we can to ensure that the care they receive will be safe and effective at all times.
Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients.
Sign up to Safety's 3 year objective is to reduce avoidable harm by 50% and save 6,000 lives.
The five Sign up to Safety pledges
Organisations and individuals who sign up to the campaign commit to setting out actions they will undertake in response to the following five pledges:
1. **Put safety first.** Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.
2. **Continually learn.** Make their organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.
3. **Honesty.** Be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
4. **Collaborate.** Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.
5. Support. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.
Further information can be found at: http://www.england.nhs.uk/signuptosafety/

South Staffordshire and Shropshire Healthcare NHS Foundation Trust has Signed up to Safety—see the Trust website for more details

National Resources

Patient Safety First is a national campaign and is sponsored by the National Patient Safety Agency and the NHS Institute for Innovation & Improvement. The campaign aims to make safety of patients everyone's highest priority with no unavoidable deaths and no unavoidable harm . The Campaign website contains a range of simple, yet effective ideas for improving patient safety within organisations. The link to the Patient Safety First Campaign website is: http://www.patientsafetyfirst.nhs.uk

Central Alerting System

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Risk management distribute relevant alerts to directorate risk co-ordinators for cascading. Further information about alerts can be found at: https://www.cas.dh.gov.uk/Home.aspx

On 10th December 2012 the Department of Health issued "Preventing Suicide– A Cross-Government Outcomes Strategy to Save Lives. The strategy is intended to provide an approach to suicide prevention that recognises the contributions that can be made across all sectors of our society. It draws on local experience, research evidence and the expertise of the National Suicide Prevention Strategy Advisory Group, some of whom have experienced the tragedy of a suicide within their families. The strategy identifies measures to support families – those who are worried that a loved one is at risk and those who are having to cope with the aftermath of a suicide. The strategy also makes more explicit reference to the importance of primary care in preventing suicide and to the need for preventive steps for each age group.
Further information can be found at the following link: http://www.dh.gov.uk/health/files/2012/09/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

This guideline is concerned with the longer-term psychological treatment and management of both single and recurrent episodes of self-harm, and does not include recommendations for the physical treatment of self-harm or for psychosocial management in emergency departments (these can be found in NICE clinical guideline 16).
Further details about this guidance can be seen at the following link: http://www.nice.org.uk/nicemedia/live/13619/57179/57179.pdf

In July 2014 the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness released its 2012 report. The report covers deaths by suicide for the period January 2000 to December 2012, people convicted of homicide (homicide convictions) between January 2000 and December 2012 and sudden unexplained deaths (SUD) in psychiatric in-patients for this period. . The link to the report on the University of Manchester website is: http://www.bbmh.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/Annualreport2014.pdf

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This Bulletin is available on the Trust website at :

www.sssft.nhs.uk/about/quality/learning-the-lessons

Or alternatively

A hard copy can be obtained by contacting the Trust Risk Management Department on 01785 7128695

- We welcome your feedback on this Learning Lessons Bulletin to help us to ensure that future editions are helpful and informative
- We would also welcome your ideas for future features or areas of learning you feel are relevant to be cascaded across the Trust

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