Being Open in NHSScotland

Guidance on implementing the Being Open principles

January 2015
**Introduction**

The national approach to learning from adverse events framework aims to support NHS boards in standardising processes for managing adverse events across NHSScotland to enable learning and improvement.

This paper presents a refresh of the National Patient Safety Agency (NPSA) Being Open Framework (2009) to support NHS boards in developing their approach to communicating and engaging with people who have suffered moderate or severe harm following an adverse event (predominately category 1 or 2 in the national framework). The information can be used to guide and inform local policy and procedures and applies across all care settings within NHSScotland.

**Background**

NHSScotland is committed to delivering high quality healthcare for the people of Scotland. The national approach to learning from adverse events aims to support NHSScotland effectively manage adverse events, to learn from them, and allow best practice to be actively promoted across Scotland so that we can continually improve the safety of our healthcare system for everyone.

Open and effective communication with people should begin at the start of their care and continue throughout all the care they receive. This should be no different when an adverse event happens. Being open when things go wrong is key to the partnership between patients and those who care for them. We have a professional duty to acknowledge when something has gone wrong and provide an honest explanation. Openness about what happened and discussing adverse events promptly, fully and compassionately can help people cope better with the after-effects of adverse events.

Being open involves:

- acknowledging, apologising and explaining when things go wrong
- if appropriate, conducting a thorough review into the adverse event which involves patients, families, carers and staff, and aims to identify lessons that will support improvements and help prevent the adverse event being repeated, and
- providing support for those involved to address any physical and/or psychological consequences of what happened.

We are committed to an open and honest approach and fully endorse the principles outlined in the NPSA Being Open Framework:

1. Acknowledgement
2. Truthfulness, timeliness and clarity of communication
3. Apology
4. Recognising expectations
5. Culture and professional support
6. Risk management and systems improvement
7. Multidisciplinary responsibility
8. Clinical governance
9. Confidentiality
10. Continuity of care
These principles align with the Scottish Government’s proposal to introduce a Statutory Duty of Candour for Health and Social Care Services (www.scotland.gov.uk/Publications/2014/10/9897). This will require all organisations providing health and social care in Scotland to tell people if there has been an event involving them where the organisation has recognised that there has been physical or psychological harm as a result of their care or treatment.

**Implementing the being open principles**

This document provides guidance to support openness with people following an adverse event. As part of our work to support implementation of these principles, NHS Lothian and the NHS National Waiting Times Centre are undertaking a year-long pilot project to:

- test opportunities for applying the principles by establishing a robust process for engaging patients/families more fully and reliably in adverse events
- establish an improved culture of openness by developing mechanisms for communicating more actively with patients and their families and to ensure staff are supported when adverse events happen, and
- inform discussions nationally on the scalability of a training package across NHS boards in Scotland and the infrastructure required at a local and national level.

The learning and outcomes from the pilot will be shared over the next 12 months and we will share good practice that is identified in other NHS board areas. The implementation guidance will also be enhanced with the learning and outcomes from the pilot work. The document will be updated and re-issued accordingly.

NHS boards’ strategic frameworks should clearly articulate the organisation’s aspirations and expectations for exemplary leadership behaviours and actions and the commitment to being open. Senior managers and Board directors should ensure the infrastructure is in place to support an open and just culture where the overall approach expected within the organisation is one of help and support rather than blame and recrimination. Staff must feel confident, supported and safe to report adverse events from which lessons can be learned and patient safety improved.

We acknowledge that this can be a complex and stressful time and a number of factors need to be considered. There may be exceptional circumstances where it is not appropriate to inform a patient, or the family or carer of an adverse event. For example, because of the distress it would cause to the patient or because the patient is not in contact with family. This judgement will be in the reasonable opinion of the healthcare professional.

The following table provides guidance on how the principles can be implemented.
<table>
<thead>
<tr>
<th>The being open principles</th>
<th>Supporting implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Acknowledgement</strong></td>
<td><strong>Policy.</strong> The adverse event policy must be clear with regards to the delegation and responsibilities of key staff for informing people when appropriate. Any circumstances where there would be an exception to informing should be outlined in the policy, for example not appropriate because of the distress it would cause or because the patient is not in contact with their family. <strong>Process.</strong> Adverse event documentation (electronic or otherwise) should be configured to ensure interactions with people are recorded and embedded in the process.</td>
</tr>
<tr>
<td>(a) All adverse events should be acknowledged and reported as soon as they are identified.</td>
<td><strong>Communication.</strong> Should be delivered in an open manner by a nominated person. The decision should consider seniority, relationship to the person, and experience and expertise in the type of adverse event that has occurred. Where possible this person should remain the primary point of communication through the duration of the engagement. Communication should:</td>
</tr>
<tr>
<td>(b) In cases where the patient, their family or carers inform healthcare staff when something untoward has happened, it must be taken seriously from the outset.</td>
<td>• be timely</td>
</tr>
<tr>
<td>(c) Any concerns should be treated with compassion and understanding by all healthcare professionals.</td>
<td>• be in a format and to the level of detail the patient, family, carers or staff requests</td>
</tr>
<tr>
<td><strong>2 Truthfulness, timeliness and clarity of communication</strong></td>
<td>• be clear - provide facts about what has happened. There should be no speculation</td>
</tr>
<tr>
<td>(a) Information about an adverse event must be given in a truthful and open manner.</td>
<td>• allow for people to be listened to and share their views, and</td>
</tr>
<tr>
<td>(b) People should be provided with a step-by-step explanation of what happened, in a manner that they can understand and to the level of detail that they request.</td>
<td>• be at regular intervals to ensure people are engaged and informed throughout the process and are aware of any delays and the reasons why</td>
</tr>
<tr>
<td><strong>Equality and Diversity.</strong> The individual needs of the person/people involved should be considered. For example, if required, be prepared to provide interpretation services or advocacy support.</td>
<td></td>
</tr>
<tr>
<td><strong>3 Apology</strong></td>
<td><strong>Spoken apologies.</strong> These:</td>
</tr>
<tr>
<td>(a) People should receive a meaningful verbal apology* as soon as possible after the adverse event.</td>
<td>• will allow face-to-face contact between the patient, their family and carers, and the healthcare team</td>
</tr>
<tr>
<td>(b) A written apology*, which states the healthcare organisation is sorry for the suffering and distress resulting from the</td>
<td>• should be given as soon as staff are aware an adverse event has happened</td>
</tr>
<tr>
<td></td>
<td>• acknowledge the emotions and distress expressed by the patient, family, carer at the outset, for</td>
</tr>
</tbody>
</table>
adverse event should be provided to signal mutual closure of the process

Scottish Public Services Ombudsman has developed guidance on apologies:

*An expression of apology does not amount to an admission of liability.

example “I can see you are upset”, “I can sense your anger/frustration”

• should be a sincere expression of sorrow or regret for the harm that has resulted, and
• should be delivered by a senior clinician involved in the patient’s care and as agreed by the healthcare team.

Written apologies.

• Should be appropriately worded, based on known facts and delivered as early as possible.
• Support may be provided by NHS board complaint managers.

Example wording:

"I am truly sorry ........."

"I would like to sincerely apologise for .........”

“ I am sorry that.........”

Promptness. Teams should not delay in giving a meaningful apology for any reason.

Note: Evidence suggests that delays are likely to increase the patient’s, their families and their carers’ sense of anxiety, anger or frustration.

4 Recognising expectations

(a) People can reasonably expect to be fully informed of the issues surrounding an adverse event, and its consequences although this should be based on the needs of the individual and their family.

Engage and communicate in line with NHSScotland’s shared values:

• Care and compassion
• Dignity and respect
• Openness, honesty and responsibility
• Quality and teamwork

All staff should treat the patient and their family empathetically, with respect and consideration.

Identify expectations. When meeting with the person (and their family), explicitly ask their preferred methods of communication and engagement. Clearly state whether expectations can be met, and if not explain why not.

Identify needs as appropriate to the patient. Ask if the person requires additional support, such as an independent patient advocate or a translator
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Other support. Where appropriate, information on local area support groups, advocacy providers and other relevant support groups should be given to the patient as soon as it is possible.</th>
</tr>
</thead>
</table>
| 5 | Culture and professional support | Culture. All NHS boards as part of their broader risk management activity are expected to foster a fair and just culture.  
Staff support. Staff should feel supported through the adverse event review process because they too may have been traumatised by being involved.  
External support. NHS boards should also encourage staff to seek support from relevant professional bodies and support services. |
| 6 | Risk management and systems improvement | Integration. Being open principles highlighted in this guidance should be integrated into NHS board adverse event reporting and risk management policies and processes.  
Engagement. The patient, their families or carers will have a unique perspective on the adverse event and should be encouraged to contribute to the review process if they so wish. They should be provided with opportunities to be listened to and to share their views.  
Improvement. The review should focus on improving systems of care and outputs should be linked to the NHS board’s quality improvement framework and improvement programmes. |
| 7 | Multidisciplinary responsibility | Ensure multidisciplinary involvement. This is critical to the being open process. It is important for NHS boards to identify clinical, nursing and managerial leaders who will support it. Both senior managers and senior clinicians who are local opinion leaders must participate in adverse event reviews. |
| 8 | Clinical governance | Learning. It is important that:  
- Findings from reviews must be disseminated to healthcare professionals promptly so that they can learn from adverse events and make service improvements.  
- Learning is shared within the specialty/clinical area and across the NHS board where relevant. Learning is also identified to share at a national level. |
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 9 | **Confidentiality**  
(a) When applying the principles of Being Open NHS boards must give full consideration of, and respect for, patient, families, carers and staff privacy and confidentiality.  
**Awareness of information sharing.**  
• Patients, family, carers and staff should be made aware that adverse event review reports will be shared for the purpose of lesson learning, education, training, reflective practice and improvement.  
• Assurance should be provided that information will be anonymised as far as possible to minimise the risk to privacy (consent is not needed for sharing of anonymised data). Be clear that information may still be potentially identifiable.  
• Review reports should be shared with those involved in the review including patients, families and carers before being shared more widely.  
**Communication.** The patient/family/carers should be informed about who will be involved in the investigation before it takes place.  
See guidance for sharing information from adverse event reviews ([Data redaction and standardised adverse event review reports link to be added](#)). |
| 10 | **Continuity of care**  
(a) Patients are entitled to expect that they will continue to receive all usual treatment and continue to be treated with dignity, respect and compassion.  
**Alternate care provision.** 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. |

The following table provides information on the actions that should be taken to support implementation. This will be enhanced by the learning and outcomes from the pilot work.
<table>
<thead>
<tr>
<th>Core responsibilities</th>
<th>Recommended actions</th>
</tr>
</thead>
</table>
| **(1) Local policy**  | • Ensure that across the NHS board, appropriate policies and procedures (for example adverse event reporting, risk, claims and complaints, communications and media policies. Acknowledge and identify how to engage and communicate with people when an adverse event has happened so that a consistent approach comes from across the NHS board.  
• Ensure that all staff who are accountable for management of the policy documents noted above fully understand the principles of being open and able to provide assurance that these are embedded within the appropriate documents. This should be captured through existing KSF and objective setting through the personal development review process. |
| (a) Review and strengthen local policies to ensure they align with the *being open* framework and are embedded with the NHS boards risk management and clinical governance processes. |

(2) Patient and family support

| (a) Patients and their families should be aware of the NHS board’s approach to being open when they are in care settings. |
| (b) Staff in corporate support functions (such as those in clinical governance and quality improvement teams) should have the information, skills and processes in place to support patients and frontline clinical staff through the *being open* process. |
| National information resources for patients/families/carers, staff and managers have been developed and form part of the toolkit being published with the refreshed national approach to learning from adverse events framework in March 2015. |

| • NHS boards should have available clear concise information, in appropriate formats, which can be given to people following a significant adverse event.  
• NHS boards should be clear on the support mechanisms available for people and communicate these at regular intervals.  
• NHS boards should ensure all core staff understand their responsibilities within the being open framework and have received appropriate training to implement being open.  
• The NHS board’s complaints manager in conjunction with the head of clinical governance (or equivalent) should ensure support services are aware of their adverse event management processes and what support is available for patients and staff. |

(3) Leadership

| (a) Make a Board-level public commitment to implementing the principles of *being open*. |
| (b) Ensure senior clinical staff from all professional groups are empowered to promote and implement being open principles when this is appropriate. |

| • The NHS board makes a publicly visible and recordable commitment to implement the principles of *being open*. Consider:  
  - commitment to *being open* should be explicit in the NHS board’s vision and values programme which should be publicly available on the NHS board’s website  
  - there should be an explicit commitment in materials used to promote *being open* across the organisation and patient information leaflets |
- sharing patient stories, including those where patients may have died or come to significant harm at the start of Board, senior team and quality and clinical governance meetings.

- The Board receives assurance that the *being open* principles are being promoted and applied throughout the organisation.

### (4) Training and support*

(a) There should be a specific section within the NHS board’s learning and development strategy that outlines how the NHS board will proportionally train its staff to implement *being open*. This strategy should also indicate how the NHS board will provide ongoing support to staff who may require it during or following adverse events.

*This will be informed by the outcomes of the pilot work.

- Work with learning and development teams to conduct an audit of current training (for example adverse event reporting, communication skills, complaints) to understand how this relates to *being open*.
- A proportionate approach should be developed for how all staff, dependant on their role will be trained and supported.
- Identify who within the NHS board can provide the required support to staff should this be required. These staff should be openly accessible to those who may need to use their support.

### (5) Visibility

(a) Raise awareness and understanding of the *being open* principles among staff, patients and the public in general.

*National resources have been developed to support awareness raising and form part of the toolkit being launched with the refresh of the national framework 2015.

- Promote the *being open* principles amongst staff through newsletters, team meetings, intranet, special interest meetings, governance meetings.
- Explicitly include reference to the NHS board’s approach to being open in staff induction programmes.
- Promote the NHS board’s commitment and approach to *being open* through local media and patient and public forums.