

## Being Open and the Duty of Candour

### Communicating patient safety incidents with patients, their families and carers

This leaflet provides information to support you with our Trust's "**Being Open and Duty of Candour**" policy at Liverpool's Women's Hospital.

You may have been given this leaflet because you or a patient you are supporting has been involved in a **Duty of Candour** incident.

This leaflet explains what **Duty of Candour** incident is and what you can expect to happen next, when an incident affects you.

### What is the Duty of Candour?

The definition of Candour is '**being open and honest**'.

Liverpool Women's Hospital is committed to delivering safe, high-quality care. However, we also recognise that healthcare is complex and situations can change rapidly and unexpectedly.

On occasion things do not go to plan and despite our best intentions and safety checks being in place, a patient may be harmed whilst in our care. A legal **Duty of Candour** reinforces the '**Being Open**' principles that we already deliver. The duty asks that healthcare providers ensure that patients, or their families (when the patient lacks capacity to make a decision regarding their own care or is deceased), are told openly, honestly and in a timely manner when mistakes happen, which are believed to have caused significant harm.

### Being open involves:

- Swiftly providing a truthful account detailing clearly what we know about the incident.
- Apologising that harm was caused.
- Providing support to patients and/ or people involved or affected by the incident.

- Investigating why the incident happened and sharing the investigation findings with you.
- Communicating any learning for the Trust from your experience and explaining how we plan to prevent it happening again.
- Duty of Candour does not affect your right to complain. You can make a formal complaint if you are not happy with any aspect of your care.

## **Which Incidents are affected by Duty of Candour?**

**Duty of Candour** applies where there has been a “notifiable safety incident” (an unintended or unexpected event which leads to harm of a patient receiving NHS care) which has resulted in one or more of the following categories of harm classified as moderate or above:

Harm may be defined as injury (physical or psychological) disease, suffering, disability or death.

### **Moderate harm**

Means an incident has occurred resulting in a moderate increase in treatment and/or which caused significant, but not permanent harm.

#### **A moderate increase in treatment includes:**

- Unplanned return to surgery
- Unplanned re-admission
- Prolonged episode of care (4-15 days extra care)
- Extra time in hospital or as an outpatient
- Cancelling of treatment because of harm caused
- Transfer to another area such as intensive care

### **Severe harm**

Means a patient safety incident that appears to have resulted in permanent harm (permanent lessening of bodily functions, sensory, motor, physiological or intellectual, including removal of wrong limb or organ or brain damage).

### **Psychological harm**

This means psychological harm which is experienced or is likely to be experienced for a continuous period of at least 28 days.

### **Death of a patient**

The next of kin and/or family will be informed of the incident. The coroner’s report will provide a key source of information that will help to complete the detail of the event leading up to the incident.

## **What can I expect to happen?**

### **Initial notification**

A senior member of staff from your healthcare team will contact you and, where possible, meet with you to notify you of the incident. We hope to do this as soon as possible, but initial notification should happen within 10 working days from the point that we realise an incident has occurred.

This designated person will ensure that during the initial discussion you are informed of any details relating to the incident that we are aware of at that time. There will also be an opportunity for you to ask questions and make comments that will be part of our investigation, as your view of the incident is important to us. You can provide questions or comments when you meet with us via letter, email or over the phone. A review of the care received will then be carried out to agree the appropriate level of investigation to be undertaken.

### **Investigation**

An investigation will then be completed within 60 working days, to fully review the incident and a report will be written. The final investigation findings will be shared with you in writing with an opportunity for a meeting to discuss the report, incident and any outcome or learning points for the Trust. The outcome of the report will be shared with you within 10 working days of the investigation being completed.

We would like to ensure that patients and their carers are fully supported during this process, so if you wish your family or other carer to also be present during any discussions, please let us know as soon as possible.

## **What treatment and care will I receive after the incident?**

You can expect to continue to receive all future treatment with respect, compassion and dignity. Nevertheless, should you wish to receive treatment from another team or organisation, we would be happy to discuss this with you, although there may be circumstances where this may not be clinically appropriate.

### **Questions or Support**

If you have any questions relating to the Duty of Candour, then you can contact:

#### **The Patient Experience Team (based at Liverpool Women's Hospital)**

Tel: 0151 702 4353 (08:30am - 04:30pm Monday-Friday)

You can also contact the following independent organisations for support or advice:

#### **The Care Quality Commission (CQC)**

The CQC is the independent regulator of health and adult social care organisations in England and is responsible for monitoring compliance with standards such as the duty of candour.

Tel: 03000 61 61 61 [www.cqc.org.uk/duty-candour](http://www.cqc.org.uk/duty-candour)

## **Action against Medical Accidents (AvMA)**

AvMA is the charity for patient safety and justice which campaigned to bring about the duty of candour.

Tel: 0845 123 2352 (10am – 5pm Monday-Friday) [www.avma.org.uk/help-advice](http://www.avma.org.uk/help-advice)

## **Patients who require this information in an alternative format:**

For patients whose first language is not English we will arrange an interpreter to be available for any meetings or discussions and any written communication will be translated for you, including this leaflet. Any other requests for alternative formats of this leaflet can be made via the Patient Experience Team.

## **Can I Complain?**

Duty of candour does not affect your right to complain. You can make a formal complaint if you are not happy with any aspect of your care.

To make a formal complaint you can contact the Patient Experience Team in one of the following ways

- By writing to the Chief Executive at Liverpool Women's NHS Foundation Trust, Crown Street, Liverpool L8 7SS
- By telephoning the **Patient Experience Team on 0151 702 4353**  
**08:30am - 04:30pm Monday-Friday**
- By email via [\*\*pals@lwh.nhs.uk\*\*](mailto:pals@lwh.nhs.uk)

**This leaflet can be made available in different formats on request. If you would like to make any suggestions or comments about the content of this leaflet, then please contact the Patient Experience Team on 0151 702 4353 or by email at [pals@lwh.nhs.uk](mailto:pals@lwh.nhs.uk)**

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