Board Bulletin
September 2016

News in Brief

The Paediatric Audiology Service being named best in the country for its newborn screening rates was one of the highlights of this month's Performance Reports Finance Director Clive Bassett told the Board.

Simon Knighton, chairman praised the executive team for their work in managing discussions following the *your care your way* procurement decision and preparing the organisation for a visit by the Care Quality Commission in October.

He also spoke of a visit to the Lymphoedema Service and the care and compassion he witnessed.

Future planning was a key topic for the Board as it heard updates on services within Bath and North East Somerset likely to be transferring to Virgin Care from April 1.

It also discussed growth plans within South Gloucestershire.

Sorry doesn't have to be the hardest word!

Sirona's ethos of Taking it Personally means saying sorry when something goes wrong and Chief Executive Janet Rowse told the board that she expects all staff to do this.

The legal requirement of Duty of Candour can be seen in the context of our ethos and the work by Sirona since it was founded to promote a culture of openness and honesty at all levels.

We know that sometimes we will make mistakes and we ask all our staff to say sorry if they get something wrong. For the most part, these mistakes are small and can be corrected straight away. However, there are occasions when our mistakes might cause some moderate or severe harm to people and, in these instances, we go beyond just saying sorry.

Lindsey Kimber, Health and Safety Manager, gave assurance to the Board that the new legislation of Duty of Candour was being promoted across Sirona. This duty sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The poster overleaf outlines the process.

Learn • Share • Improve

Lindsey went on to tell the Board about a wide range of initiatives in place across Sirona.

There are currently 41 Health and Safety Champions across all of Sirona services; they have formed a network to share information about health and safety, share learning from adverse events across teams and help staff develop skills.

Feedback from an initial newsletter for Champions was so positive, one is now produced for all members of staff covering a range of topics. This work is complemented by Safety Clouds which are themed to share learning for clinical and non-clinical staff.

Managers from across all services also meet regularly to review serious incidents such as individuals developing pressure ulcers or falling to ensure learning is shared across the organisation.

Lindsey said: "The future is focused on continuing with the improvements in the last 12 months by reviewing systems and developing tools to assist teams to manage their health and safety effectively.

"The levels of assurance for health and safety matters has increased vastly in the last few years and the improvements will continue."

After Board Janet said: "Although the Duty of Candour is a legal requirement, it is also the right thing to do and I want everyone to know that in Sirona we support all our staff to provide high quality and safe services and when something does go wrong we will say sorry and do everything we can to share the learning across the organisation."

Duty of Candour (Saying Sorry!)

What is duty of candour?

Duty of candour is a regulation which details a professional responsibility to be honest with patients/ service users when things go wrong, regardless of whether a complaint has been made or a question asked about it.

What does it mean in practice?

Duty of candour comes into effect if an incident has occurred where actual harm resulted in moderate or severe impact to a patient/service user, or a catastrophic incident occurred where the death of a patient/service user was unavoidable.

There are some specific requirements that need to be followed and these must begin within 10 working days of the incident being identified.

You must:

- Report the incident immediately – visit our intranet for more information about reporting incidents
- Speak to the patient/service user and provide as much information and support as possible in relation to what has gone wrong
- Apologise, then follow up the apology by giving the same information in writing
- Answer honestly any questions they might have and provide updates on any further enquiries
- Ask the patient/service user if they have any specific questions they would like answering as part of a formal investigation, should one need to be conducted
- Offer the patient/service user the opportunity to receive the outcome of the investigation

Taking it Personally may sometimes mean saying 'Sorry' when something goes wrong.

Support – for the service user involved in the event, their next of kin and any staff member

Offer – to share information and to meet to discuss any expectations from investigations

Record – your conversations and your apology by writing to the service user and/or their next of kin

Results – give the results of investigations to the service user/next of kin (as agreed with them)

Yes! – Sirona expects all staff to be open and honest with service users and/or their next of kin when something has gone wrong.

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