East Midlands
Neonatal Operational Delivery Network

NETWORK GUIDELINE

Guideline:	**Duty of Candour – A Network Approach**
Version:	**2**
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Approval:	**Clinical Governance Group**
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Consultation:	**Clinical Governance Group**
Distribution:	**Neonatal Units within EMNODN**
Risk Managed:	**Ensuring appropriate communication between parents, providers and CenTre Neonatal Transport service around clinical incidents**

This document is a guideline. Its interpretation and application remains the responsibility of the individual clinician, particularly in view of its applicability across the different Trusts in the East Midlands Neonatal Operational Delivery Network. Please also consult any local policy/guideline document where appropriate and if in doubt contact a senior colleague.

Caution is advised when using guidelines after a review date.

In the exceptional circumstances that a Trust in the EMNODN opts not to follow an EMNODN approved guideline/monograph/SOPs they should complete an EMNODN Derogation Form.

REVIEW AND AMENDMENT LOG

Version	Type of Change	Date	Description of Change
1	-	May 2016	New Guideline
1	No change	May 2020	Joint CNN & TPN Guideline transferred to EMNODN Guideline format
2	Document details	July 2024	Revised national classifications

Whilst it is well understood that parents need to be informed of any adverse incidents that occur during neonatal care, the statutory requirements of Duty of Candour mean that a formalised process for sharing information with parents, when babies are moved between units, is required.

NHS Resolution guidance states that apologising does not affect indemnity cover and is:

- Always the right thing to do.
- Not an admission of liability.
- Acknowledges that something could have been done better.
- The first step to learning from what happened and preventing it from recurring.

The Requirements:

The following actions should be undertaken in the event of any incident that could result in moderate or severe harm, prolonged psychological harm or death – REGARDLESS OF FAULT.

- Recognise the incident and report it accordingly.
- Inform parent/carer and /or their advocate.
- Apologise to the parent/carer and /or their advocate.
- Fully explain what the short- and long-term effects might be following the incident.
- Offer an appropriate remedy or support to put matters right whenever possible.
- Write to parent/carer and /or their advocate following discussions.
- Document the incident and all discussions accurately.
- Investigate the incident thoroughly.
- Update the parents / carers, and or their advocate accordingly.

These actions must be undertaken in a timely manner, ideally within 7 days.

This can create difficulties when an incident has occurred in one hospital, or during transport, and the baby is then residing in a different hospital. It is also possible that the baby's mother may still be in the original hospital.

It is essential that each trust has an internal process for managing incidents, and that this is reviewed in light of the recent statutory duty of candour requirements.

Neonatal Incidents:

Incidents that do not involve transfer of an infant should be managed as per the trusts risk management policy, and duty of candour requirements met.

If the infant is transferred then it is essential that clear communication between the referring team, receiving team, and transport service where appropriate, occurs so that a plan for communicating with parents/ carers and/or their advocate according to the duty of candour requirements is met. Due to the timeliness of the duty of candour requirements, it is practical that the consultant who is in the hospital within which the parents are located will usually have these discussions. However, the use of Teams could be considered to enable a facilitated conversation between all parties. Whilst an initial discussion may be had, detailed discussions should not occur until all the fact finding about the incident has taken place, by liaising with the consultant responsible for the infant's care when the incident occurred. If there is to be a further incident investigation, and the opportunity for the parents/ carers and /or their advocate to discuss this with the team where the incident occurred, then reference to this opportunity should be made during the DOC discussion and documentation.

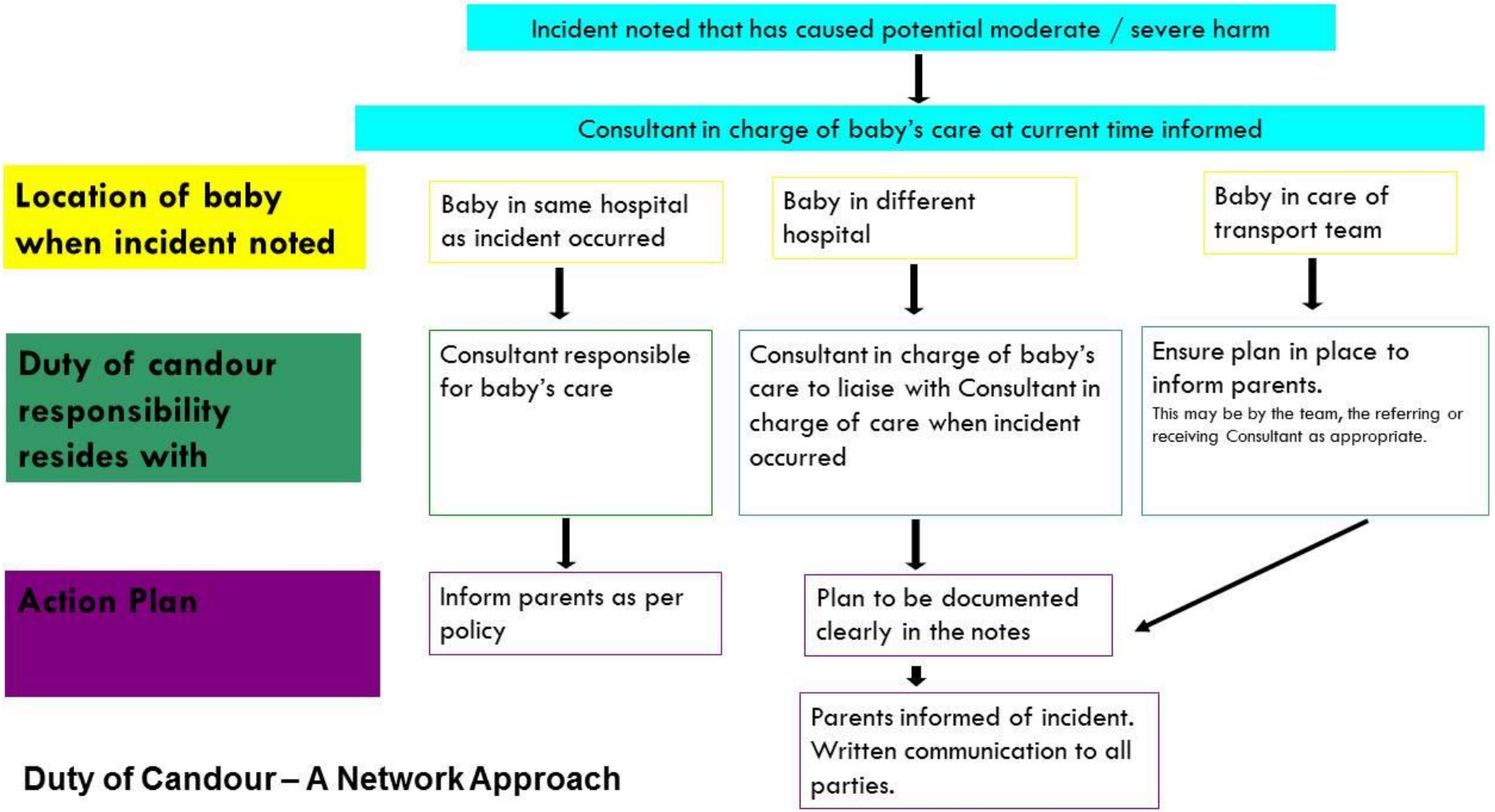
The process of managing neonatal incidents is summarised in the flow-chart below (Fig-1).

Notifiable Patient Safety Incidents (formerly Serious Untoward Incidents SUIs) should continue to be reported through current pathways and copied to the Network team.

Obstetric Incidents:

If an obstetric incident or concern is brought to a neonatologist/paediatrician's attention, the neonatal teams have a duty of candour to ensure that this is raised and reviewed. As neonatal teams do not have obstetric expertise, they should not be discussing the details of obstetric concerns with parents. Again, this may prove difficult when parents have moved from one unit to another. Liaison with referring and receiving unit obstetric staff to ensure that the parents are informed may be required. Again, the use of Teams may be considered to facilitate these conversations.

Fig-1



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