DUTY OF CANDOUR POLICY

POLICY

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Approving Body	Patient Safety Committee		
Date Approved	February 2024		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
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	X		
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Version	4.2		
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Supersedes	• Duty of Candour Policy, v4.2 issued May 2023 • Duty of Candour Policy, v4.0 issued May 2023 – May-2026 • Duty of Candour SOP, v3.0, Issued March 2020 to Review Date Feb 2023		
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Legal and/or Accreditation Implications	Not Applicable		
Target Audience	This Policy applies to all staff groups, all clinical areas and all patients receiving care from the Trust, and includes any failure in care or treatment whether they are identified as a result of a: • Patient Safety Incident (PSI) • Concern or complaint • Claim		
Review Date	January 2027		
Sponsor (Position)	Chief Nurse		
Author (Position & Name)	Gemma Barker, Quality Governance Lead for Medicine		
Lead Division/ Directorate	Corporate		
Lead Specialty/ Service/ Department	Nursing/ Governance Support Unit		
Position of Person able to provide Further Guidance/Information	• Gemma Barker, Quality Governance Lead for Medicine; and • Candice Smith, Director of Nursing Quality and Governance		

Associated Documents/ Information	Date Associated Documents/ Information was reviewed
1. General Post Incident Duty of Candour Notification Letter Template (locally maintained within GSU) 2. General Post Incident Duty of Candour Notification Letter Template (with condolences) (locally maintained within GSU) 3. General Post Incident Duty of Candour Letter Template EXTENSION (locally maintained within GSU) 4. Duty of Candour Form (locally maintained within GSU) 5. Letter offering to share final investigation report (locally maintained within GSU) 6. Duty of Candour Information Leaflet (available on external website via link) 7. Duty of Candour Information Leaflet (large print) (available on external website via link)	1. May 2023 2. May 2023 3. May 2023 4. May 2023 5. May 2023 6. March 2023 7. March 2023
Template control	April 2023

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1.0 INTRODUCTION

Sherwood Forest Hospitals NHS Foundation Trust (hereafter referred to as "The Trust") is committed to ensuring that its ethical, professional, contractual and statutory responsibilities and Duty of Candour are met following a patient safety incident.

The Duty of Candour places a requirement on providers of health and adult social care to be open with patients when things go wrong, ensuring that honesty and transparency are the norm. Duty of Candour became a statutory requirement for all CQC registered Trusts from 27th November 2014 meaning the Trust must be open and transparent with service users about their care and treatment, including when it goes wrong.

This policy has been developed in line with the following National documents:

- Regulation 20 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014
- NHS Constitution (January 2021)
- NHS Standard Contract 2022/23
- Being Open Framework (National Patient Safety Agency (NPSA), 2009)

The Trust must promote a culture that encourages candour, openness and honesty at all levels. This is an integral part of a culture of safety that supports organisational and personal learning, alongside a commitment to being open and transparent at board level.

Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must also be open and honest with regulators, raising concerns where appropriate.

Any suspected breaches of the professional Duty of Candour by staff who are professionally registered will be dealt with through the Policy, procedure and guidance in the Trust's 'Disciplinary Policy' which may involve referral of cases to the relevant regulatory body.

2.0 POLICY STATEMENT

This Policy is issued and maintained by the Chief Nurse (the sponsor) on behalf of Sherwood Forest Hospitals NHS Foundation Trust ('the Trust'), at the issue defined on the front sheet, and replaces all previous versions.

This policy addresses the Trust response to the statutory and professional responsibility of Duty of Candour when a patient safety incident is identified. Regulation 20 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 states that a notifiable patient safety incident must meet all 3 of the following criteria:

1. It must have been unintended or unexpected
2. It must have occurred during the provision of an activity we regulate
3. In the reasonable opinion of a healthcare professional, already has or might result in death, or severe, or moderate harm to the person receiving care.

The Trusts Incident Reporting Policy and Procedures encourages all staff to report all patient safety incidents including those where there was no harm, or it was a 'near miss'. The Trust Incidents Reporting Policy and Procedures provides definitions on level of harm in association with the National Reporting and Learning Systems (NRLS) definitions. Where patient safety incidents occur which do not meet the notifiable safety incident criteria statutory Duty of Candour will not apply. The chart below provides and overview of the Trusts level of response to patient safety incidents:

Grade of incident based on trust apportioned harm.	Level of response
No harm	The GMC and NMC guidance is that these are evaluated on a case by case basis as to whether or not the patient safety incident is discussed with patients, their families or carers.
Low harm	Investigation, analysis and communication of the incident and the subsequent implementation of actions identified will occur at local level. These events will be reported to the patient safety team via Datix and will be reviewed centrally to detect themes and trends. Communication should be open and discussions should be between the staff providing the patients care and the patients, their family or carers. This should be reported in the medical notes and on the Datix system.
Moderate harm (Statutory Duty of Candour Applies)	If the level of harm is identified to be moderate or higher at the patient safety incident review group meeting it will be deemed a “notifiable safety incident”. A conversation must be held with the patient or their representative, in person either face to face or on the telephone within 10 working days of it being recognised as a “notifiable safety incident”. This should be followed up in writing with a letter approved and signed by the Director of Nursing Quality and Governance which includes an apology, an explanation, details of the investigation and when any feedback should be expected. A point of contact should be given and the opportunity to ask any questions given. The patient should receive written results of any investigations with 10 working days of the completion of the enquiry unless the patient has specifically declined to be given this information.
Severe or Catastrophic Harm. (Statutory Duty of candour Applies)	If the level of harm is identified to be severe or catastrophic at the patient safety incident review group meeting it will be deemed a “notifiable safety incident. The executive team and Divisional Management Team for the division will be notified at the earliest opportunity. A conversation must be held with the patient or their representative, in person either face to face or on the telephone within 10 working days of it being recognised as a “notifiable safety incident”. This should be followed up in writing with a letter approved and signed by the Director of Nursing Quality and Governance which includes an apology, an explanation, details of the investigation and when any feedback should be expected. A point of contact should be given and the opportunity to ask any questions given. There will be a formal investigation which should be offered, in writing to the patient within 10 working days of the completion unless the patient or representative has specifically declined to be given this information.

The Policy is designed to provide a best practice framework, based on published guidance, to create an environment where patients, their representatives and staff feel supported, and have the confidence to act appropriately, and for ensuring that all communications with relevant people are open, honest and occur as soon as reasonably practicable.

It is aimed at any healthcare staff member, clinical or non-clinical, responsible for making sure that the infrastructure is in place to support openness between healthcare professionals and patients and/or their carers following an incident. It describes the processes of Being Open and the Duty of Candour with patients and gives advice on the 'dos and don'ts' of communicating with patients and/or their representatives following harm.

3.0 DEFINITIONS/ ABBREVIATIONS

Being Open	The process by which the patient, their family and their carers are informed about a patient safety incident involving them.
Candour	A duty to disclose incidents that may not be immediately obvious to the patient. Any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in: a) The death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or b) Severe harm, moderate harm or prolonged psychological harm to the service user.
Complaint	Any expression of dissatisfaction with care provision, or a perceived grievance or injustice.
DMT	Divisional Management Team
FLO	Family Liaison Officer
GSU	Governance Support Unit
Never Event	A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures had been implemented by the healthcare provider.
NRLS	National Reporting and Learning System – the electronic system by which all NHS Trusts inform the Care Quality Commission of patient safety incidents.
Notifiable Patient Safety Incident	An unintended or unexpected incident that occurred in respect of the service user during the provision of regulated activity, that in the reasonable opinion of a healthcare professional, could result in, or appear to have resulted in either: • The death of a service user, where the death relates directly to the incident rather than to a natural cause of the service user's illness or underlying condition • Severe harm, moderate harm or prolonged psychological harm to the service user
Operational day	An operational day is a day other than a Saturday, Sunday or Bank Holiday in England).
PSIRG	Patient Safety Incident Review Group
PSC	Patient Safety Committee
PSIRF	Patient Safety Incident Review Framework
Staff	All employees of the Trust including those managed by a third party on behalf of the Trust.
Trust	Sherwood Forest Hospitals NHS Foundation Trust ('the Trust').

Definitions of Levels of trust apportioned harm:

Harm	Any physical or mental damage or injury
Low Harm	Minimal harm to patient but required extra observations or minor treatment. Please note: neurological observations following an un-witnessed fall are not classed as extra observations as this level of observations is dictated by the Trust's Head Injury Policy on Hospital Premises and may not be in response to harm. Therefore only the harm not the level of observation should be recorded.
Moderate Harm	Harm that requires a moderate increase in treatment; and significant but not permanent harm. Examples of moderate harm: An unplanned 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 treatment area (such as intensive care).
Severe Harm	Any unexpected or unintended incident that causes permanent or long term harm.
Catastrophic Harm	Death as a direct result of a patient safety incident. If the patient's death is not directly associated with the incident the degree of harm should be proportionate to the incident details and not the death.
Prolonged Psychological Harm	Psychological harm which a service user has experienced, or is likely to experience for a continuous period of at least 28 days

4.0 ROLES AND RESPONSIBILITIES

4.1 **The Trust Board** – Actively promotes an open and fair culture that fosters peer support and discourages the attribution of blame. In addition, the board actively promotes shared learning across the organisation.

4.2 **Patient Safety Committee** – Receives a quarterly report on compliance with the Duty of Candour regulations as part of the Trust's assurance process.

4.3 **Chief Executive Officer** – Ensures that there is Board-level public commitment to implementing the principles of 'being open' and the statutory Duty of Candour, and that the notification requirements to relevant persons are met.

4.4 **Executive Chief Nurse** – Has responsibility for the development, implementation and enforcement of this Policy, including educating healthcare professionals about 'Being Open' and the statutory Duty of Candour.

4.5 **Executive Chief Nurse and Clinical Directors** – Are responsible for ensuring that healthcare professionals who are involved in patient safety incidents graded moderate or above are supported in the candour process, including the organisation of formal or informal debriefing of the clinical team involved in the patient safety incident, and sharing the lessons learned across the organisation.

4.6 **Divisional Management Teams (DMT)** – Consisting of Clinical Chair, Divisional Director of Nursing and Divisional General Manager are responsible for allocating an appropriate Duty of Candour Lead for each notifiable incident within their Division. The DMT will inform the nominated person of their role as Duty of Candour Lead for the notifiable incident. The DMT are responsible for monitoring compliance with Duty of Candour within their Divisions via their monthly Divisional Governance Packs and weekly Divisional Investigation Trackers provided by the Governance Support Unit.

4.7 **Governance Support Unit (GSU)** – Led by the Director of Nursing Quality and Governance. The GSU has responsibility for supporting the Chief Nurse with the implementation of the strategic and operational aspects of safety including Duty of Candour and the provision of expert advice, resources, training and education as necessary.

4.8 **Director of Nursing Quality and Governance** – Provides oversight of the Duty of Candour processes within the Trust. This will include monitoring, audit and provision of compliance data to Divisions and the PSC.

4.9 **Head of Legal Services** – Is responsible for ensuring that the Policy meets the statutory requirements of the Duty of Candour. Requesting reports for litigation/coroner, ensure clinicians are aware that a Datix is entered retrospectively if an unreported incident is identified.

4.10 **All Trust staff** – All staff, including temporary, agency or volunteer staff, have a responsibility for identifying actual or potential hazards, safety incidents and risks and reporting/escalating issues in accordance with this and other relevant policies. All communication with the patient, their family or carers must be explicitly and contemporaneously documented in the medical records. All staff involved in an incident, including non-clinical staff, staff from other teams and locum staff should be offered a debrief and be signposted to further sources of support.

4.11 **Duty of Candour Lead/ Family Liaison Officer** - This will be the person who is deemed best to communicate with the patient/family/representative, to inform them there has been an incident that may have caused harm and offer an apology. The Duty of Candour Lead / Family Liaison Officer will be responsible for:

- Making the initial disclosure of harm as soon as possible after the incident is identified (within 10 days).
- Apologising to the patient/family/carer, giving an initial explanation of the incident (which is known at that point).
- Signposting the patient/family/carer to appropriate support.
- Discussing the investigation process with the patient/family/carer and asking if they have any concerns regarding the investigation and conveying these concerns to the investigator(s) if not present.
- Agreeing an on-going point of contact with the patient/family/carer.
- Recording evidence of the Duty of Candour process – on Datix and in the patients notes.
- Agreeing with the patient/family/carers how often updates will be provided and who will be providing these if it is a different person.
- Recording current communications with the patient/family/carer in the report and on Datix.
- Providing a copy of the investigation report to patient/family/carer, once signed off by the Trust.

5.0 APPROVAL

- Following consultation, this revised policy was approved by the Patient Safety Committee.

6.0 DOCUMENT REQUIREMENTS (POLICY NARRATIVE)

6.1. The Trust Supports a Culture of Openness, Honesty and Transparency

The Trust promotes a culture of openness, honesty and transparency in its delivery of care. This general obligation includes apologising and explaining to patients or their representatives when a patient has been harmed or there is a potential for learning to improve care delivery and the experience of patients.

The Trust expects all staff members to adhere to a culture of openness and transparency.

This Policy acknowledges there are a multitude of different obligations and "Duty of Candour".

The Statutory Duty of Candour is contained within Regulation 20 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014 which sets out what is required of all providers, such as the Trust. The Trust acts in line with Regulation 20 to ensure it is open and transparent with people who use services and other "relevant persons".

Regulation 20 (1) states "Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity".

Staff must also have awareness of further obligations and Duty of Candour aside from those set out under Regulation 20. Some of these obligations apply to the Trust and its staff:

The Contractual Duty of Candour (Specific Condition 35 of the Standard Contract), as between the Integrated Care Board (ICB) and the Trust:

- Openness and Honesty when things go wrong: the professional Duty of Candour (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/candour---openness-and-honesty-when-things-go-wrong).
- NHS Constitution (https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england).
- Regulation 20 Duty of Candour (http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour).

Others apply to healthcare professionals only (GMC and NMC Guidance):

- GMC Good Medical Practice Guidance (2019)
- NMC Guidance – The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (October 2018)

This Policy therefore reflects this multitude of obligations known collectively as the "Duty of Candour".

This Policy will refer to "notifiable safety incidents" as set out under Regulation 20. In these circumstances the Statutory Duty of Candour will apply.

There are significant sanctions for breaching any of the Duty of Candour obligations. These sanctions are set out in section 6.4.2.

Under Regulation 20 relevant persons must be informed of a "notifiable safety incident". This is a mandatory field in the on-line e reporting incident form (Datix).

6.2. Process for acknowledging, apologising and explaining when things go wrong.

(See also Appendix A)

6.2.1 Detecting and recognising an incident

The Being open and Duty of Candour process begins with the recognition and acknowledgement that a patient has suffered harm. In all cases relating to incidents, the Trust's Incident Reporting and Investigation policy must be followed.

As soon as a patient safety incident is identified the actions required are: The first step of the process is to recognise and determine whether a notifiable safety incident has occurred and whether it is appropriate to apply the Duty of Candour.

An incident can be identified by any of the following mechanisms including (not an exhaustive list):

- Via staff at the time of the incident.
- Via staff retrospectively.
- By the relevant person raising a concern at the time or via a complaint, whether verbal or written. Where a complaint indicates a notifiable safety incident has occurred, the investigation supersedes the complaint. The concerns raised in the complaint will form part of the investigation terms of reference and be answered via the investigation process.
- Via the incident reporting system.
- Via concerns raised by a post mortem result.
- Via concerns raised by external bodies, such as the Coroner.
- Via concerns raised by other care providers.

As soon as a patient safety incident is identified the actions required are:

- First priority: prompt and appropriate clinical care with prevention of further harm. If additional treatment is required, it should happen as soon as reasonably practicable after a discussion with the patient (or carer if the patient is unable to participate in discussion) and with appropriate consent.
- Incidents must be reported through the Datix incident reporting system in accordance with Incident Reporting Policy.

6.2.2 Multi-disciplinary Discussions

Following identification of an incident, a preliminary team discussion should be undertaken at the earliest opportunity with the Division to scope the incident and establish:

- Timeline of the event and basic clinical facts.
- Assessment of the incident and determine level of immediate response required
- Individual responsible for discussing/ liaising with the relevant person.
- Whether support is required for the relevant person.
- Immediate support required for staff involved.
- A clear communication plan.

Escalation to the Patient Safety Incident Review Group (PSIRG) will be in line with the Trust Incident Reporting Policy, Patient Safety Incident response Plan and Divisional Standard Operating Procedures.

If an incident has been escalated to the PSIRG meeting a rapid review / scoping paper will have been submitted and an investigation deemed to have been commenced. In

line with the Trust's culture of openness and transparency the relevant person should be informed of the outcome of this meeting, even in the event that the meeting concludes that no further investigation should take place (e.g. because it does not reach the threshold of harm). In all cases the relevant person should be offered a summary of the findings up to this point, an opportunity to contribute their perspective or ask questions they feel are relevant and an opportunity to see the final report of any further investigation that is undertaken.

In line with the Trust's culture of openness and transparency if a full investigation is opened where a "near miss" has occurred, where there has been an incident but which has caused no harm or harm which has not reached the threshold defined above but the potential for significant learning is identified though the scoping process the relevant person should be informed. The patient and relatives are a potential source of important information.

Healthcare Professionals should use their discretion. Informing the relevant person of a near miss may aid their recovery however, it may also cause harm and distress. The Duty of Candour response to date will be discussed and next steps agreed at the PSIRG and recorded in the minutes along with the person responsible for communicating with the patient or relative/representative and initial terms of reference for the investigation.

6.2.3 Identifying who should be responsible for undertaking the formal notification to the patient or representative (Duty of Candour Lead)

Under PSIRF, incidents will be reviewed by division in the first instance and escalated to PSIRG in line with the Trust's PSIRP. At the point at which moderate harm is identified statutory DOC is enacted and the patient or relevant persons must be informed as soon as possible. The individual nominated to act as Duty of Candour Lead for the incident:-

- Have a good relationship with the relevant person.
- Have a good understanding of the relevant facts.
- Be senior enough or have sufficient experience and expertise in relation to the type of incident to be credible to the relevant person.
- Have excellent interpersonal skills, including being able to communicate with the relevant person in a way they can understand.
- Be willing and able to offer an apology, reassurance and feedback to the relevant person.
- Be able to maintain a relationship with the relevant person and to provide continued support and information.
- Be culturally aware and informed about the specific needs of the relevant person.
- Be fully familiar with the obligations under the Duty of Candour
- Have the confidence to escalate any concerns and / or seek further advice where necessary.

In addition to statutory DOC, incidents that are subject to a PSII, Learning Teams, Thematic review, After Action review and Rapid review will have DOC consideration.

6.2.4 Initial discussions with the relevant person

The NHS contract requires statutory Duty of Candour to be commenced within 10 operational days of a notifiable patient safety incident being identified.

The following factors should be taken into account when considering the timing of the discussion:

- Clinical condition of the patient. Some relevant persons may require more than one meeting to ensure that all the information has been communicated to and understood by them.
- Availability of key staff involved in the incident and in the Duty of Candour process.
- Availability of the relevant person(s).
- Availability of support staff, for example a translator or independent advocate, if required.
- Patient preference (in terms of when and where the discussion takes place and who leads the discussion).
- Privacy and comfort of the relevant person.
- Arranging any meeting in a sensitive location.

The discussion must:

- Be given in person by the most senior clinician or nurse where appropriate
- Inform the patient as soon as reasonably practicable after becoming aware that the notifiable safety incident has occurred and provide support to them in relation to the incident.
- Provide an account of the incident: facts known at the time
- Advise the patient what further investigation will take place
- Provide a verbal apology and an expression of regret for the harm caused. Expressing regret for harm caused is not the same as admitting liability and the risk of litigation should not prevent an apology.
- Be followed up in writing giving the same information – letters to be approved and signed by the Director of Nursing Quality and Governance

In determining the manner of the notification, apology and explanation, the Duty of Candour Lead must have due regard to Service Condition 13.2 of the Standard Condition (SC) (Equity, of Access, Equality and Non Discrimination). This stipulates there must be no discrimination on the grounds of age, disability, gender reassignment, marriage, civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other non-medical characteristics, except as permitted by the Law.

Apologies should not be formulaic but genuine and healthcare professionals should consider the following points when communicating with a relevant person:

- Provide information in a way they can understand.
- Speak to them when they are best able to understand and retain information.
- Give a personalised apology which must be documented in case notes.
- Tell them who to contact to ask any further questions or raise concerns.
- Tell them what steps will be taken to prevent future events reoccurring.

Every effort should be made to provide the patient with a verbal apology prior to providing the written notification however, it is recognised that on rare occasions, this may not be possible. All efforts made are to be recorded on Datix. The written notification should also reflect the efforts made to provide a verbal apology.

6.2.5 Written notification

The Trust must ensure they follow the verbal apology with a written notification to the relevant person.

The Trust must provide a written apology and formal notification of Duty of Candour as soon as possible following the notifiable incident being identified by the PSIRG. The ***Duty of Candour Notification letter template*** / ***Notification letter with condolences template*** are locally maintained within GSU and are associated documents to this Policy. It is good practice to send the formal Duty of Candour Notification letter by Registered Mail.

Written information must include:

- Offer a meeting to set TOR
- All information that was included in person in the initial notification.
- An apology.
- Results of any enquiries made since the notification in person.
- The opportunity for comments/concerns to be included in the investigation.
- The date it is anticipated the final investigation will be completed.
- Offer the draft report

The Trust is required to provide written notification within 10 operational days of the recognition of the incident. The GSU will complete the written notification once they have received confirmation from the duty of candour lead that a verbal conversation has taken place with the relevant person and this will be signed by the Director of Nursing Quality and Governance (or nominated deputy).

6.2.6 Follow up and sharing of findings

On completion of the investigation, the Duty of Candour lead must contact the relevant person to offer a step-by-step explanation of events and circumstances that resulted in the incident and any pertinent information. Learning and improvements made should be shared with the relevant person and an anonymised copy of the final report, shared.

Best practice is to offer to share the report at a face-to-face meeting rather than by post. However, the Duty of Candour lead must be guided by the wishes of the relevant person, and where appropriate, with the support of the Family Liaison Officer. Where a final investigation report is shared by post this must be sent via recorded delivery. GSU can provide support with this if required. The Family Liaison Officer / Governance Support Unit must also contact the relevant person as a matter of course to advise about any extensions/ delays to the expected report completion date.

Where there is a coronial inquest or investigation being undertaken the GSU will ensure the final report is shared with the Trusts legal team who will share this with the appropriate coroner's team.

The Action Plan - names redacted for any final report shared with the patient or family.

The Trust aims to provide this information to the relevant person within 10 operational days following the investigation being signed off as complete.

6.2.7 Contacting the relevant person

The Trust must make every attempt to contact the relevant person through all available means of communication. All attempts to contact the relevant person must be documented. If the relevant person does not want to be contacted or informed of the notifiable safety incident, their wishes must be respected and a record must be kept. If the relevant person has died and there is nobody who can lawfully act on their behalf record must be kept.

6.2.8 Record keeping from communications with patient/relevant person

The Duty of Candour Lead must keep a record of all communication with the relevant person in the incident form on Datix using the Duty of Candour tab.

6.2.9 Additional notifications

The Trust requires all notifiable safety incidents to be reported to Local Risk and Management systems (Datix Incident reporting system) in accordance with the Incident Reporting Policy and Procedures.

6.3. Provision of Additional Support

6.3.1 Support of the relevant person

The Trust's Family Liaison Officer (FLO) will attempt to establish contact with the patient or their representative following formal Duty of Candour to agree the level of support required and the frequency of contact. An opportunity will be provided to the patient or their representative to attend a meeting to discuss any questions or concerns they have, in addition to the feedback form being shared alongside the written DoC letter. At any face-to-face meeting, they should be encouraged to be accompanied by another family member / friend / representative. Where appropriate, an independent advocate or interpreter should be offered. The relevant person is also at liberty to request a second or independent review and this should be facilitated. The Family Liaison Officer will work closely with the patient or their representative, in addition to the Patient Experience Team to triangulate any concerns raised previously and to ensure regular updates are provided as agreed.

Where a relevant person has died or is unlikely to regain consciousness information should be conveyed in a compassionate way to their representatives. The healthcare professional must show respect to bereaved people and take into account any known wishes of the relevant person when they were alive. This includes what should happen upon their death and who information is shared with.

6.3.2 Information on how relevant persons can access additional support services

The relevant person can be offered additional support from:

- Governance Support Unit can be contacted on internal extension 4716
- Family Liaison Officer on internal extension 6978
- Interpretation services via: - 03333449473
- Chaplaincy via internal extension 3047 (Kings Mill), 5643 (Newark) and 5011 Mansfield Community Hospital

External bodies which may be able to provide support for the relevant person include:

- CAS - Independent Complaints Advocacy Services

- CRUSE (Bereavement Counselling Support)
- IMCA – Independent Mental Capacity Advocate Service

6.3.3 Where the patient is assessed not to have capacity

Where the relevant person has undergone a mental capacity assessment and is found to lack capacity, the principles of Duty of Candour still apply. In circumstances where the relevant person has a health and welfare lasting power of attorney (LPA), it may be a legal requirement that they are informed dependent on the terms of the LPA.

In this case the Attorney(s) under the LPA would be deemed the relevant person. If there is no LPA for the relevant person, it is best practice that other relevant persons (i.e. family/carers) are informed of the incident unless the relevant person has previously indicated they do not want particular other relevant persons involved in their healthcare. In this situation the family member/s would be considered the relevant person. The occurrence of this conversation and the grounds for it must be recorded in the relevant person's medical record.

Healthcare professionals should consider involving the Independent Mental Capacity Advocacy Service (IMCA) at any notification or follow-up meeting where the relevant person lacks capacity. The purpose of the IMCA is to help particularly vulnerable people who lack the capacity to make important decisions and who have no family or friends that it would be appropriate to consult about those decisions. The role of the Independent Mental Capacity Advocate (IMCA) is to work with and support people who lack capacity and represent their views to those who are working out their best interests. A copy of "Making Decisions - The Independent Mental Capacity Advocate Service" can be obtained from the following link:
https://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/making-decisions-opg606-1207.pdf

The Trusts safeguarding team and / or legal team can be contacted if further advice is required for patients who lack capacity.

6.3.4 Children and young people

A young person (anyone aged 16-17) is presumed capable of consenting to their own medical treatment in line with the Mental Capacity Act 2005. However, it is still considered to be good practice to encourage the young person to involve their family.

The Courts have stated that children under 16 years old who understand fully what is involved in the proposed procedure can also give consent. This is sometimes known as Gillick competence. Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the notification process after a notifiable safety event.

The opportunity for the person with parental responsibility (usually the parents) to be involved should still be provided unless the child expresses a wish for them not to be present. Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the person with parental responsibility (usually parents) alone or in the presence of the child.

In these instances, the parents' or person with parental responsibility's views on the issue should be sought. In these instances, the person with parental responsibility is the relevant person.

6.3.5 Relevant persons with a mental disorder

The only circumstances in which it is appropriate to withhold a notifiable safety incident from a relevant person with a mental disorder is when advised to do so by a Consultant Psychiatrist who feels it would cause adverse psychological harm to the patient. However, such circumstances are rare, and a second opinion (by another Consultant Psychiatrist) would be needed to justify withholding information from the relevant person.

Only in exceptional circumstances is it appropriate to discuss a notifiable safety incident with a representative of the relevant person without their express permission.

Staff are advised to discuss such a proposed action with a senior member of the GSU and Caldicott Guardian. Any decision to withhold information on these grounds should be clearly recorded in the medical records.

6.3.6 Relevant persons with learning disabilities

Some relevant persons with Learning Disabilities may need some additional support to understand the Duty of Candour and notification process. All attempts should be made to include the relevant person in the process by use of reasonable adjustments such as: additional time to understand the process, alternative communication methods (use of easier reading information, pictures/symbols, use of everyday simple language), support in understanding by involving family members or familiar workers, use of an advocate to ensure the relevant person's views are considered and discussed. If the mental capacity of a relevant person is in question then a formal assessment of mental capacity should be undertaken.

6.3.7 Relevant persons with different language or cultural considerations

The need for translation and advocacy services and consideration of special cultural needs (such as for relevant persons from cultures that make it difficult for a woman to talk to a male about intimate issues) must be taken into account when planning to discuss a notifiable safety event. It would be worthwhile to obtain advice from an advocate or translator before the meeting on the most sensitive way to discuss the information. Avoid using unofficial translators and/or the relevant person's family or friends. Information can be found on the Interpreting Services Intranet on how to contact the Trust's contracted services including working hours and how to contact the interpreting service out of hours. Information can also be found on the site for how to raise a request for face-to-face interpreter or a request for translating a document.

6.3.8 Relevant persons with different communication needs

A number of relevant persons will have particular communication difficulties, such as a hearing impairment. Plans for the notification meeting should fully consider these needs. Knowing how to enable or enhance communications with a relevant person is essential to facilitating effective Duty of Candour and notification. This involves focussing on the needs of the relevant person and being personally thoughtful and

respectful. For Information on how to contact the interpreting and translation service, see section 6.3.7 above.

6.3.9 Legal affairs

Where the Duty of Candour raises specific ethical or legal considerations, the Department of Legal Affairs can be contacted for advice via internal extension 3257.

6.3.10 Professional support

(TRIM
It can be very traumatic for healthcare staff to be involved in a notifiable safety incident. The Trust is committed to ensuring staff feel supported through the process. Staff are also encouraged to seek support from their relevant professional body. The Trust will:

- Actively promote an open and fair culture that fosters peer support and discourages blame.
- Educate and support all Duty of Candour leads on a case-by-case basis and keep a record of all staff trained in Duty of Candour.
- Provide facilities for formal and informal debriefing.
- Provide opportunities within the clinical schedule for staff to discuss the matter.
- Provide advice and training on the management of notifiable safety events.
- Provide information and support systems to support staff who have been distressed by incidents.
- Ensure staff can access support from the Professional Midwifery/Nurse Advocate services
- Develop specific system of support through staff support services. (TRiM)
  Additional, confidential support is available to staff from:
- Occupational Health via internal ext. 3780
- Chaplaincy via internal ext. 3047 (Kings Mill), 5643 (Newark) and 5011 (Mansfield Community Hospital)
- Governance Support Unit ext. 4716
- Staff are encouraged, if appropriate to seek advice from their trade union representative.

Staff will not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or threat to their registration. Where there is evidence to believe that punitive disciplinary action may follow or criminal act has occurred, the NHS Improvement Just Culture Guide should be used to ensure a robust and consistent approach. The Just Culture Guide aims to help the NHS move away from attributing blame and instead find the cause when things go wrong. The goal is to promote fair and consistent staff treatment within and between healthcare organisations. Further information can be found in Appendix B.

Incidents relating to employee performance or conduct should be referred to the appropriate divisional Human Resources (HR) Advisor and managed in accordance with Trust disciplinary and performance management procedures.

6.3.11 Risk management and systems improvement

The Trust supports a thematic approach to looking at the causes of notifiable safety events. The focus is on improving systems of care. Further details are available in the 'Incident Reporting Policy and Procedures'.

6.3.12 Multi professional responsibility

The Trust acknowledges that relevant person care is delivered through multi professional teams and the investigation into a notifiable safety event, complaint or claim is focused on systems and processes, rather than individuals. For this reason, senior clinicians and managers must participate in the investigation process.

Senior Healthcare Professionals must also:

- Have responsibility to encourage openness and honesty in reporting notifiable safety incidents and near misses. Clinical leaders should foster a culture of learning and improvement.
- Ensure systems are in place to give early warning signs of any failure or potential failure in the clinical performance of individual in the team.
- Ensure systems including audit are in place to monitor, improve and review the quality of the team's work.

However, in line with both the NMC and GMC Guidance all healthcare professionals must fully co-operate in any investigation undertaken by the Trust.

If an expert opinion is sought, individuals must declare any conflict of interest.

6.3.13 Confidentiality

Details surrounding a notifiable safety event are confidential. Full consideration should be given to maintaining the confidentiality of the patient, carers and staff involved, in line with the 'Confidentiality Policy'.

It is good practice to inform the relevant person about who will be involved in the investigation and give them the opportunity to raise any objections. Communication outside the clinical team should be strictly on a 'need to know' basis. Equally the relevant person may need specific questions answered by the investigation process and should be given the opportunity to raise these.

6.3.14 Continuity of care

Relevant persons have the right to expect that their care will continue, and that they will receive all their usual treatment with the care, respect and dignity that they are entitled to. If the relevant person has a preference for their care to be delivered by another team, the appropriate arrangements should be made.

Further, any notifiable safety incident should be communicated to the relevant person's GP if they are going to be receiving on-going care in the community.

6.3.15 Requirements for documenting all communication

All discussions and communication with the relevant person should be carefully detailed in the medical case notes. Additionally, in reviewing the care the interaction with the relevant person should be detailed within the investigation report.

Where the communication happens as part of the complaints or claims process, this should be documented within the case file.

6.3.16 Process for encouraging open communication between organisations,

teams, staff, relevant persons.

Where the notifiable safety incident, complaint or claim involves outside agencies (e.g. other healthcare providers, the Commissioners or social services) whether raised by The Trust or the other agency, there is an obligation to fully co-operate with them and to communicate collaboratively with them.

6.4. Sanctions for non-compliance with the Duty of Candour

Various sanctions apply for non-compliance with the Duty of Candour.

6.4.1 Statutory Duty of Candour

It is a criminal offence not to notify the relevant person of a notifiable safety incident or fail to meet the requirements for such notification. If the Trust is found guilty of such an offence, they will be liable to conviction of a fine. The CQC can prosecute without serving written notice first.

6.4.2. Contractual Duty of Candour

If there is a breach of the contractual Duty of Candour to notify relevant persons of a suspected or actual patient safety incident the commissioning body can recover from the Trust either the cost of the episode of care or up to £10,000 if the cost is unknown.

Where a Trust breaches any requirement there are a range of actions available for the commissioner:

- Requiring a direct written apology and explanation for the breach to the individual from the Trust's Chief Executive Officer.
- Publication of the breach on the Trust's website.
- Notification to the CQC by commissioners.

6.4.3 Breach of NMC/GMC Guidelines

A breach of GMC/NMC Guidance can lead to professional regulatory proceedings being bought against the Healthcare Professional. This can result in conditions being attached to a healthcare professionals' registration or removal of licence.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Compliance will be monitored by the Director of Nursing Quality and Governance with weekly update to the Divisional Management Teams through weekly Investigation Trackers, monthly Governance Packs and monthly Compliance Report as part of the Serious Incident Report to PSC.

Minimum Requirement to be Monitored **(WHAT – element of compliance or effectiveness within the document will be monitored)**	**Responsible Individual** **(WHO – is going to monitor this element)**	**Process for Monitoring e.g. Audit** **(HOW – will this element be monitored (method used)**	**Frequency of Monitoring** **(WHEN – will this element be monitored (frequency/ how often))**	**Responsible Individual or Committee/ Group for Review of Results** **(WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)**
Process for: Encouraging open communication Acknowledging, apologising and explaining for notifiable incidents. Requirements for truthfulness, timeliness and clarity of communication	Governance Support Unit / Family Liaison Officer Divisional Management Teams. Executive Team. Director of Nursing Quality and Governance Governance Support Unit / Family Liaison Officer. Director of Nursing Quality and Governance	Monitoring of compliance data. Weekly review of all outstanding DOC notifications at the Investigation review meeting held in GSU with the Director of Nursing Quality and Governance, the Quality Governance Leads and Family Liaison Officer. Through weekly Divisional Governance Meetings. Through monthly PSIRF Report to PSC. DOC Policy Divisional Governance Reports on a monthly basis (to Divisions and DMT)	Weekly Weekly Monthly On scheduled policy review Monthly.	Director of Nursing Quality and Governance PSC. Divisional Management Teams.

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used)	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
		DOC Compliance Report on a monthly basis as part of the PSIRF update (to PSC).	Monthly.	
Provision of additional support as required	Governance Support Unit / Family Liaison Officer.	Review meeting held in GSU with the Director of Nursing Quality and Governance, Quality Governance Leads and Family Liaison Officer.	Weekly.	Director of Nursing Quality and Governance and Quality Governance Leads
Requirements for documenting all communication	Director of Nursing Quality and Governance	Investigation review meeting held in GSU with the Director of Nursing Quality and Governance and Quality Governance Leads.	Weekly	Director of Nursing Quality and Governance

8.0 TRAINING AND IMPLEMENTATION

- There is a duty of candour e-learning package which all duty of candour leads are required to have completed.
- Upon identification of the named Duty of Candour Lead, the GSU will provide additional training on an 'as required' basis.
- Training records for investigating officers and named Duty of Candour Leads who have been trained in Duty of Candour will be maintained by the GSU.
- Duty of Candour is included in Preceptorship training for all Registered Nurses and Midwives.

9.0 IMPACT ASSESSMENT

This document has been subject to an Equality Impact Assessment, see completed form at Appendix C.
This document is not subject to an Environmental Impact Assessment.

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS:

Evidence Base:

1. The NHS Constitution (amendment January 2021)
2. NHS Standard Contract 2022/23
3. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
4. Care Quality Commission Regulation 20: Duty of Candour (December 2022)
5. Openness and honesty when things go wrong: the professional Duty of Candour (GMC and NMC Joint Statement, March 2022)
6. Being Open (NPSA, 2004, reissued November 2009)
7. NHSLA (September 2018) Saying Sorry
8. Serious Incident Framework. NHS England. March 2015
9. Just Culture Guide (NHS Improvement 2018)
10. The NHS Patient Safety Strategy (February 2021)
11. Patient Safety Incident Response Framework (August 2022)

Related SFHFT Documents:

- Claims Handling Policy
- Receiving, investigating, responding to and learning from complaints, concerns and compliments policy
- Incident Reporting Policy
- Safeguarding Adults Policy
- Safeguarding Children and Young People Policy
- Mental Capacity Act (MCA) Policy
- Speaking Up Policy (previously Raising Concerns – Whistleblowing Policy)
- Medication incidents/errors – guideline for managing staff involved
- Confidentiality Policy
- Disciplinary Policy

11.0 KEYWORDS

Candid; to be open; openness and honest; transparent; transparency; honesty; governance; standard operating procedure; SOP; notification

12.0 APPENDICES

Appendix A – Flowchart to ensure Duty of Candour is followed for every Moderate, Severe and Death PSI

Appendix B – Just Culture Guide (NHS Improvement 2018)

Appendix C – Equality Impact Assessment

Appendix A – Flowchart to ensure Duty of Candour is followed for every Moderate, Severe and Death PSI

There are two types of duty of candour, statutory and professional. Both the statutory duty of candour and professional duty of candour have similar aims – to make sure that those providing care are open and transparent with the people using their services, whether or not something has gone wrong. This flowchart refers to the process for statutory duty of candour.

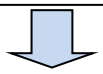
The Trust is subject to the NHS Standard Contract and must therefore ensure the statutory duty of candour notification be made within 10 operational days (an operational day is a day other than a Saturday, Sunday, or bank holiday in England) of the incident being confirmed as notifiable at the Patient Safety Incident Review Group (PSIRG).

The notification must:

- Be given in person by one or more representatives of the Trust.
- Include an apology
- Provide a true account of what happened, including all known facts.
- Explain to the relevant person what further enquiries or investigations you believe to be appropriate.
- Follow up by providing this information, and the apology, in writing, and providing an update on any enquiries.
- Be recorded in the patients medical records and on the relevant datix.

At the time of the incident being identified:

A representative of the area/ speciality must make every effort to contact the patient or their representative to inform them of the incident and offer a verbal apology as soon as reasonably possible. The information given to the patient should be factually correct and not misleading and should inform them of any further enquiries or investigations believed to be appropriate.



The apology should be recorded in the patients' medical records and within the relevant datix.

Following incident review at the Divisional Meetings:

The level of Trust apportioned harm and impact on the patient will be determined at divisional level . If the Divisional Team are unable to reach a decision, then the incident will be escalated to the PSIRG. If the incident is graded as moderate, severe or catastrophic, Statutory Duty of Candour applies.

A Duty of Candour lead will be identified at the Divisional meeting. This should be a member of staff who has completed the e-learning duty of candour package. In most cases this should be a clinical staff member from the appropriate specialty/area.

The Duty of Candour lead will contact the patient or their representative either in person or via telephone and provide them with an update following the review meeting and advise on the next steps within 10 operational days of the divisional meeting. The Duty of Candour lead will provide the individual with the opportunity to disclose any concerns they wish to be reviewed as part of the investigation. During this phone call the address which the written apology will be posted to will be confirmed and arrangements regarding frequency and method of contact confirmed. A summary of the verbal apology and explanation of the next steps must be recorded in the patients' medical records and on Datix. Where required, the Duty of Candour lead will also signpost support services for the patient or their representative should they wish to access them and will advise that the Family Liaison Officer will contact them as a designated point of contact.

The Duty of Candour Lead will feedback to the Governance Support Unit (GSU) any concerns raised by the patient or their representatives. The GSU will ensure any concerns are communicated to the lead investigator and documented on the relevant Datix.

The Duty of Candour Lead will feedback to the Governance Support Unit (GSU) confirmation of the patient or their representative's address. The GSU will produce a written apology using the appropriate template (Duty of Candour – Notification Template Letter or Duty of Candour – Notification Template Letter (with condolences)) which will be reviewed and signed by the Director of Nursing Quality and Governance or their nominated deputy. The apology will include contact details for the Duty of Candour Lead, overseeing Quality Governance Lead and a generic GSU telephone number.

A Duty of Candour Information Leaflet (also available as a **large print version**), a pre-paid envelope and duty of candour form will be included with the apology and will be posted via royal mail signed for delivery. The royal mail reference number will be recorded on the datix.

A copy of the written Duty of Candour Notification letter will be attached to the Datix and Duty of Candour tab on Datix be updated.

Following incident review at the Patient Safety Incident Review Group (PSIRG):

Where formal Duty of Candour has not been instigated , at divisional levelthe level of Trust apportioned harm and impact on the patient will be determined at the PSIRG. If the incident is graded as moderate, severe or catastrophic, Statutory Duty of Candour applies.

A Duty of Candour lead will be identified at the PSIRG meeting. This should be a member of staff who has completed the e-learning duty of candour package. In most cases this should be a clinical staff member from the appropriate specialty/area.

The Duty of Candour lead will contact the patient or their representative either in person or via telephone and provide them with an update following the review meeting and advise on the next steps within 10 operational days of the PSIRG meeting. The Duty of Candour lead will provide the individual with the opportunity to disclose any concerns they wish to be reviewed as part of the investigation. During this phone call the address which the written apology will be posted to will be confirmed and arrangements regarding frequency and method of contact confirmed. A summary of the verbal apology and explanation of the next steps must be recorded in the patients' medical records and on Datix. Where required, the Duty of Candour lead will also signpost support services for the patient or their representative should they wish to access them and will advise that the Family Liaison Officer will contact them as a designated point of contact.

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A copy of the written Duty of Candour Notification letter will be attached to the Datix and Duty of Candour tab on Datix be updated.

When an investigation extension is required:

The Family Liaison Officer or a member of staff from the GSU will contact the patient or representative to advise about any extensions to the expected report completion date.

The family liaison officer or member of staff from GSU will then produce an Extension letter (using the Extension letter template) and this will be posted to them via Royal Mail signed for delivery. A copy of the extension letter will be attached to the Datix.

When an investigation is complete and signed off:

Once the draft report is complete, the Family Liaison Officer, or staff from the GSU will contact the patient or their representative to provide an opportunity for them to review the findings and to comment on any factual inaccuracies. Any feedback provided will be shared with the QGL for consideration.

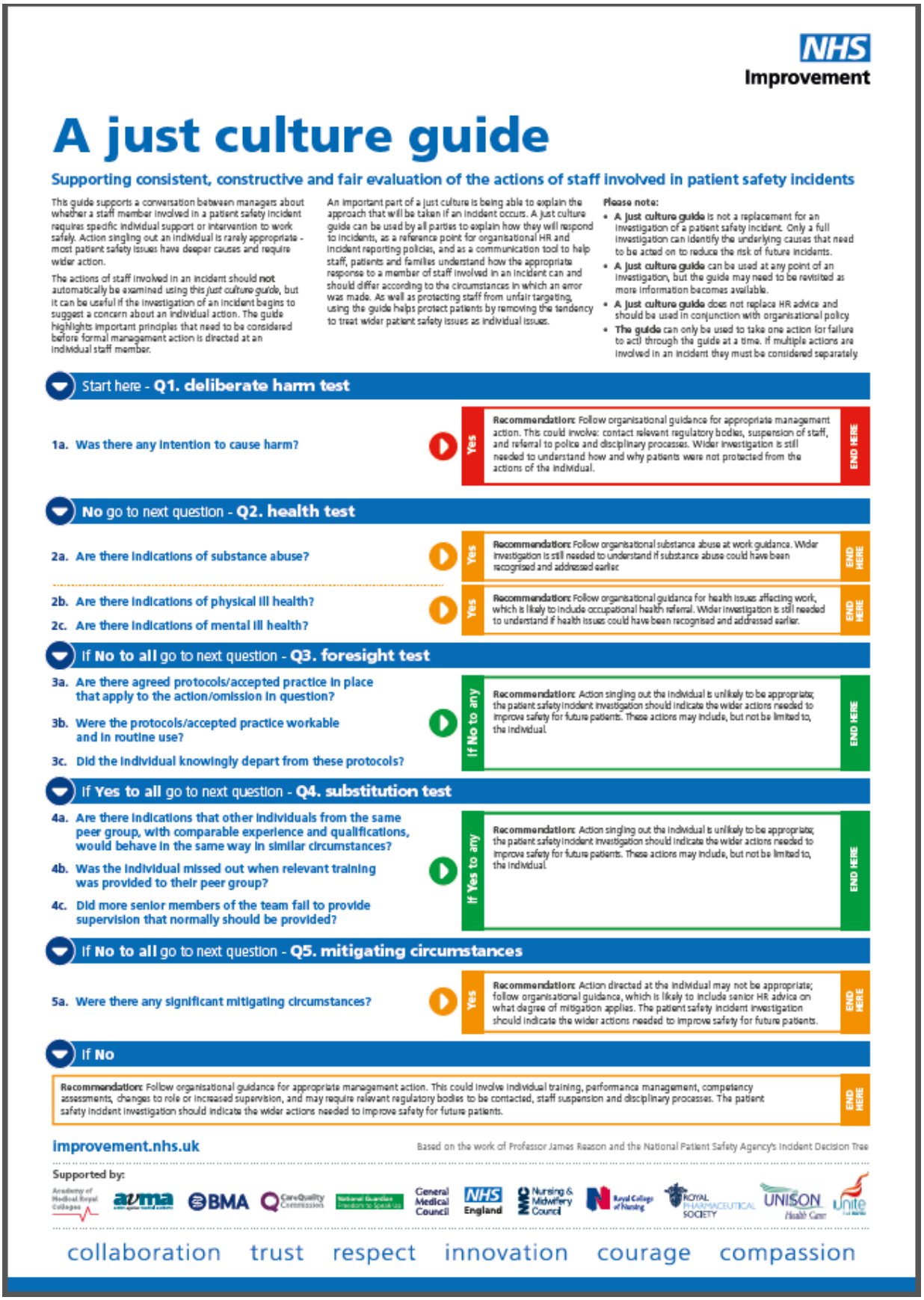
The final report's action plan should include an action to share the findings of the Investigation with the patient and/or their representative. The action plan must be deleted or have any staff names redacted prior to sharing the final report with the patient/family.

The GSU will arrange to share the findings from the investigation with the patient or their representative within 10 operational days of the report being Signed Off by the Trust.

Best practice is to offer to share the report at a face-to-face meeting rather than by post however must be guided by the wishes of the relevant person. Where a final investigation report is shared by post this will be completed by the GSU using the offer to share letter template. The report will be sent via signed for delivery and ensure the reference number is recorded on the Datix.

If on the rare occasions that sharing the findings have been deemed to be inappropriate the reasons for this must be documented within the Duty of Candour section on Datix.

Appendix B



NHS Improvement

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this *just culture guide*, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy
- **The guide** can only be used to take one action for failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately

Start here - Q1. deliberate harm test

1a. Was there any intention to cause harm?

Yes → **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. **END HERE**

No go to next question - Q2. health test

2a. Are there indications of substance abuse?

Yes → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. **END HERE**

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

Yes → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. **END HERE**

If No to all go to next question - Q3. foresight test

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

If No to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. **END HERE**

If Yes to all go to next question - Q4. substitution test

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

4b. Was the individual missed out when relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

If Yes to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. **END HERE**

If No to all go to next question - Q5. mitigating circumstances

5a. Were there any significant mitigating circumstances?

Yes → **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. **END HERE**

If No

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. **END HERE**

improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by:

collaboration trust respect innovation courage compassion

APPENDIX C – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: DUTY OF CANDOUR POLICY			
New or existing service/policy/procedure: Existing			
Date of Assessment: 05/01/2024			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	None known	Applies to all patients irrespective of protected characteristic group.	None known
Gender	None known	Applies to all patients irrespective of protected characteristic group.	None known
Age	None known	Applies to all patients irrespective of protected characteristic group.	None known
Religion	None known	Applies to all patients irrespective of protected characteristic group.	None known
Disability	None known	Applies to all patients irrespective of protected characteristic group.	None known
Sexuality	None known	Applies to all patients irrespective of protected characteristic group.	None known
Pregnancy and Maternity	None known	Applies to all patients irrespective of protected characteristic group.	None known
Gender Reassignment	None known	Applies to all patients irrespective of protected characteristic group.	None known
Marriage and Civil Partnership	None known	Applies to all patients irrespective of protected characteristic group.	None known

Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None known	Applies to all patients irrespective of protected characteristic group.	None known

What consultation with protected characteristic groups including patient groups have you carried out?

- None required as the policy and procedures apply to all patients irrespective of protected characteristic group.

What data or information did you use in support of this EqIA?

- None required as the policy and procedures apply to all patients irrespective of protected characteristic group.

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- None.

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

~~High Level of Impact/Medium Level of Impact/~~**Low Level of Impact** *(Delete as appropriate)*

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment: Gemma Barker, Quality Governance Lead and Candice Smith, Director of Nursing Quality and Governance

Signature:

Date: 05.01.2024