Duty of Candour Policy
Being Open, Honest and Transparent

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1 Introduction

Candour is about being open, honest and transparent with patients if something goes wrong with their treatment or care that causes or has the potential to cause harm and distress. Duty of Candour is a **contractual obligation** that requires NHS provider organisations to implement and measure the principles of being open.

The Care Quality Commission (CQC) **Fundamental Standard Regulation 20: Duty of Candour** (Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulation 2015) is a **statutory responsibility** introduced in response to the Francis Inquiry at the Mid Staffordshire NHS Foundation Trust.

All Healthcare Professionals have a Duty of Candour **professional responsibility** to be honest with patients when things go wrong. This is described in NMC and GMC The Professional Duty of Candour, and forms part of a joint statement from eight regulators of healthcare professionals in the UK.

The Duty of Candour, whether **contractual, statutory or professional**, rests on the same fundamental principle: being open, honest and transparent with patients in your care. Your professional Duty of Candour applies to all incidents.

Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) fully support the Duty of Candour and culture of candour as a prerequisite to improving patient safety and the quality of service user and carer experience. **This is a process rather than a one off event.**

2 Why we need this policy

This policy informs all Trust staff of their roles and responsibilities relating to the Duty of Candour and culture of candour, it is about being open, honest and transparent with patients, carers and or families and giving an apology should something go wrong in the course of the care and treatment we provide that causes or has the potential to cause harm or distress.

This policy, as well as informing staff of their role in relation to Duty of Candour and culture of candour informs service users, relatives and carers of what they can expect from the professionals involved if something goes wrong with the care and treatment we provided.

2.1 Purpose

The purpose of this policy is to set out the Trust’s expectation for all Healthcare Professionals and the contractual, statutory and professional responsibility to be honest with patients in their care if things go wrong. The Trust will support staff by fostering a just culture.

Professor Don Bewick advises “to abandon blame as a tool and to trust the goodwill and good intentions of staff and help them to achieve” in providing excellent care.
2.2 Objectives

The core objectives of this policy are to ensure that:

- All Trust staff are aware of their responsibility to implement the CQC Regulation 20: Duty of Candour and the CQC’s expectation of a culture of candour of what to do should something go wrong in the course of providing the patient’s care and/or treatment.
- All nurses and doctors are aware of The NMC and GMC guidance: Openness and honesty when things go wrong: The Professional Duty of Candour (June 2015) http://www.gmc-uk.org/DoC_guidance_english.pdf_61618688.pdf
- Service users/patients and their family or carers have the Duty of Candour and or culture of candour applied if something goes wrong with the care and treatment we provided and are given appropriate support.
- That ‘saying sorry’ is a genuine and meaningful communication made in person unless the patient (family or carer) states otherwise.

3 Scope

3.1 Who this policy applies to

This policy applies to all Trust staff at all times; we all have a responsibility for being open, honest and transparent with service users, their families and carers.

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! Being open, honest and candid relies on staff and their rigorous reporting of patient safety incidents. The Trust encourages staff concerned about any non-reporting or concealment of incidents, or practices that presents a serious risk to patient safety to raise their concerns through the Freedom to speak up Guardian or the Trust’s Whistleblowing Policy.

3.2 Roles and responsibilities

This policy informs all Trust staff of their role and responsibility regarding openness, honesty and transparency if something goes wrong with a patient’s care or treatment.

<table>
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<tr>
<th>Role</th>
<th>Responsibility</th>
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| Chief Executive and Trust Board | • To ensure and demonstrate the Trust commitment to the Duty of Candour principles and standards and ensure organisational systems are in place for implementation of the Duty of Candour.  
• To require all staff to meet the Duty of Candour principles. |
| Clinical Directors, Medical Staff, Heads of Service, Heads of Nursing, Locality Managers, Service Managers, Modern Matrons, Ward and Team | • To foster a culture of openness and ensure all staff are supported to follow the principles of Duty of Candour in being open, honest and transparent and they are aware of the risks to the Trust if they do not.  
• And as part of that to provide or coordinate an apology and explanation to the service user in person (unless requested not to), their family or carers where appropriate as soon as possible when something has gone wrong. |
Managers and all Registered Professionals across Health and Social Care

- To promote the Duty of Candour Policy: Being Open, Honest and Transparent and review processes through QuAG’s
- To fulfil their duty to:
  - Be open and honest with the patients in your care and or those close to them if something goes wrong. Saying sorry when it is identified as your role to do so working with the responsible Senior Operational Manager and Head of Nursing
- HCPC standards of conduct, performance and ethics

The Patient Safety, Complaints, Legal Services and Compliance Team

These corporate Trust departments have a responsibility to ensure that open communication is promoted at all times:

- Ensuring the Datix reporting system is used to its full potential
- Ensuring all patient safety incidences, complaints and claims are handled in an open and honest way
- Processing information consistently and precisely and in a meaningful way

All Trust Employees

- To be open and honest with the Trust.
- To encourage a learning culture by reporting adverse incidents that led to harm as well as near misses.

The Trust requires all employees to be open, honest and candid and that staff who admit to being involved in accidents, incidents, near misses or errors will be supported and treated fairly.

4 Policy

4.1 Duty of Candour

As a Trust we must act in an open, honest and transparent way with service users and or relevant persons in relation to care and treatment provided whilst carrying out a regulated activity. A regulated activity means the care and treatment we provide.

In the Regulation 20: Duty of Candour an apology means an expression of sorrow or regret made in respect of a notifiable safety incident.
A **notifiable safety incident** is categorised as:

- **Moderate Harm (short term harm)**
  Where safety incidents are moderately serious in nature or consequence that lead to a moderate increase in treatment e.g. unplanned return to surgery, unplanned readmission, prolonged episode of care, extra time in hospital or as an outpatient, cancellation of treatment or transfer to another treatment area such as Intensive Care Unit (ICU).

- **Prolonged psychological harm (expected to last more than 28 days)**

- **Severe Harm (permanent or long-term)**
  Incidents that are serious in nature or consequence and may be reportable on the Strategic Executive Information System (STEIS)

- **Catastrophic Harm** An unexpected death (this will be a STEIS reportable incident). The death must directly relate to the incident and not the natural course of the service users illness or underlying condition.

**Duty of Candour** applies to any unintended **OR** unexpected **notifiable safety incident** that could have or did lead to harm for anyone to who we provide care and treatment (**regulated activity**) to.

In deciding if Duty of Candour applies the Healthcare Professional must consider whether the incident was an unintended **OR** unexpected incident (it can be either or both for Duty of Candour to apply). And that the incident occurred during the provision of a regulated activity that could result in or appears to have resulted in a **notifiable safety incident**.

The initial decision made at the time of the incident as to whether Duty of Candour processes should be applied must be based on the reasonable opinion of a Healthcare Professional in accordance with the information available to them at the time.

An incident of self-harm is not automatically Duty of Candour applicable, this will depend on whether there is an action, omission or mistake in the course of the patient’s care and treatment that has resulted in a notifiable safety incident. For example, if a patient in the community self-harms and the outcome is considered Moderate Harm because treatment in ICU is required and the risk summary and risk management plan is up to date and fully implemented, Duty of Candour may not apply. This will depend on whether the Healthcare Professional knows at that time if there was action, omission or mistake in the course of the patient’s care and treatment that has resulted in a notifiable safety incident; this may not be clarified until the Head of Service review has been completed.

The decision for Duty of Candour relating to acts of self-harm in an inpatient setting will also depend on whether the Healthcare Professional knows at that time if there was action, omission or mistake in the course of the patient’s care and treatment that has resulted in a notifiable safety incident. On an inpatient ward we have an additional responsibility to provide a safe environment and any action, omission or mistake may be more apparent. The Healthcare Professionals in the Multi-disciplinary team will make the Duty of Candour
decision; again this may not be fully clarified until the Head of Service review has been completed. The culture of candour will always apply.

When a notifiable incident in the course of care and treatment has occurred the decision as to whether Duty of Candour applies is made by the Healthcare Professional at the time and they need to ask themselves:

Do I believe this harm has resulted from actions, omissions or mistakes made in the course of this person’s care and treatment

The CQC Fundamental Standard REGULATION 20: Duty of Candour says:

For duty of candour to apply the incident must occur in the provision of care treatment (regulated activity) and at the time it only needs to be in the opinion of the Healthcare professional that Duty of Candour applies. All decisions and actions relating to Duty of Candour and or culture of candour must be recorded in the patient’s case notes on PARIS.

The statutory Duty of Candour role you must undertake when something has gone wrong with a patient’s care and/or treatment (regulated activity) as in a notifiable safety incident classed as moderate or severe harm or an unexpected death is to ensure the following:

**STEPS 1 to 7 for Duty of Candour and Culture of Candour**

1. Immediately, or as soon as is reasonably practicable after a notifiable safety incident classed as moderate or severe harm or an unexpected death, a senior member of the Multi-Disciplinary Team person must:
   a. **Notify the relevant person** the incident has occurred (see part 2 below), **say you are sorry** for what has happened and **fully explain what is known at the time** along with information about any likely **long and short term effects**
   b. **Provide reasonable support to the relevant person** from the point they are informed and include family or carers where appropriate

2. The **notification given must**:
   a. **Be given in person by one or more of the Multi-Disciplinary Team (MDT)** and include an account of what happened which, to the best of the registered persons knowledge is true, with all facts that the registered person knows about the incident at that time
   b. **Advise the relevant person what further enquiries** into the incident the registered person believes are appropriate
   c. **Give an apology** (say ‘I am sorry for what happened’)
   d. **Advise the relevant person what will happen next** in terms of their care and treatment (offer an appropriate remedy and or support to put the matter right, if this is possible)
   e. **Advise the relevant person of what further enquiries will be made** about the incident and **record all of what has been said to the relevant person by who on their care record**, which in TEWV is case notes on Paris

3. The **notification given in step 2 must be offered a written notification given or sent to the relevant person containing**:
   a. The information provided under paragraph 2
b. Details of any enquiries to be made and the results of these enquiries
   c. An apology

If a letter is offered and accepted this must be recorded in case notes on PARIS, if the patient rejects the letter this must be recorded in case notes on PARIS.

4. **If the relevant person cannot be contacted in person or declines to speak to the member of the MDT part 2a and 2b do not apply. A record of every attempt to contact or speak to the relevant person must be recorded** and in TEWV this is in the patient's case note on Paris.

5. **A copy of all correspondence/written notifications to the relevant person must be kept**; in TEWV this is in letters on Paris.

6. Remember to report the incident on Datix.

7. If the patient has died a condolence letter and the initial apology for what has happened will be sent out from the Head of Service

A Duty of Candour check list for actions can be found on Appendix 1

**What the CQC can do**

The intention of Regulation 20 is to ensure Providers are open and transparent with people using their service and other ‘relevant persons’ in relation to care and treatment provided. CQC can prosecute for a breach of parts 20 (2) (a) and 20(3) of the regulation without serving a warning notice.

20 (2) (a) as soon as reasonable practicable after becoming aware that a notifiable safety incident has occurred a registered person must (a) notify the relevant person that the incident has occurred and be given in person by one or more representatives of the registered person.

20(3) the notification must be given to the relevant person that the incident has occurred and be given in person by one or more representatives of the registered person.

**Reporting and review of Incidents**

*(Please see Incident reporting and serious incident review policy)*

a. All incidents must be reported on Datix and will be reviewed in the patient safety and central approval team daily clinical huddle. There will be an initial review of the type of review required and a decision made to the type of review required.
   i. In serious incidents the patient safety team carries out a review involving a Root Cause Analysis. Steps 1 to 7 apply and if the patient has died condolences offered by the Head of Service.
   ii. In a moderate harm level incident a Head of service review is required.

b. The Locality Manager/Service Manager/Modern Matron for the Locality where the incident occurred has the responsibility to ensure Duty of Candour actions for moderate, severe and death incidents are completed.

c. The Head of Service Review will confirm whether all of the Duty of Candour actions required as in steps 1 to 7 above have been carried out and recorded on Paris.
d. The Head of Service review goes to the Locality QuAG where final confirmation of Duty of Candour being implemented is recorded. This is then sent to the patient safety inbox who update on Datix that Duty of Candour applies.

e. For incidences of severe harm or death the final decision for Duty of Candour is taken at the Director Panel where after a full review of the patient’s care and treatment (regulated activity) demonstrates the care and treatment was not of the standard expected and or there was an action, omission or mistake in the course of the care provided to the patient.

f. Where the Director Panel agree that the statutory role Duty of Candour applies, a letter is sent to the relevant person from the Executive Director of Nursing via the Patient Safety Team, this will saved in the patient’s Paris record in letters.

g.  

4.2 A Culture of Candour (being honest, open and transparent)

The culture of candour role Healthcare Professionals must undertake when something has gone wrong with a patient’s care or treatment that has resulted in low harm or no harm

- **No harm (near miss)**
  A safety incident that had the potential to cause harm but was prevented resulting in no harm, loss or damage.

- **Low Harm (minimal harm)**

This reflects a safety incident that resulted in a minor or undesirable or no serious outcome.

1. Immediately if it has been recognised that something has gone wrong with the patient’s care and treatment, meet with the patient and where appropriate, the patient’s family, carer or advocate
2. Explain what has happened and any effects they may experience and say you are sorry
3. Offer an appropriate remedy and or support to put the matter right (if possible)
4. Ensure someone is available to give them emotional support
5. Record in the patient’s case notes on Paris what has happened, who explained to the patient what had gone wrong and that an apology was made for the error, omission or mistake

The Ward or Team manager has the responsibility to coordinate the culture of candour response and support the Healthcare Professionals involved.

4.3 Saying sorry to the patient

Saying sorry does not mean that you are admitting legal liability for what has happened and does not constitute an admission of negligence. This is reinforced and supported by the NHS Resolution (formerly NHS Litigation Authority (NHSLA)) who advises that saying sorry is the right thing to do. It is not expected that the staff involved in explaining to the relevant person what has gone wrong and then making the apology is responsible for what has happened.
When saying sorry you will be expected to:

- Speak to the patient (relevant person) in person in a place and at a time when they are best able to understand and retain the information and has someone with them who can support them
- Give the patient (relevant person) the information they want or need to know in a way that they can understand and avoid jargon
- Take into account the patient (relevant person) may find receiving the information distressing and to carry this out in a considerate way, respecting their right to privacy and dignity
- Say “I am sorry” rather than a general expression of regret about the incident on the organisations behalf
- Make sure the patient (relevant person) knows how to contact the healthcare team to ask additional questions
- Give information about Independent Advocacy, counselling and or details for other mechanisms of support

**Good Practice is to say:**

- I'm sorry ‘X’ happened
- We're truly sorry for the distress caused
- I'm sorry, we have learned that ‘X’ happened

**Never say things like:**

- I'm sorry you feel like that
- We're sorry if you're offended
- I'm sorry you took it that way
- We're sorry but....

### 4.4 Saying sorry to the family and or carers

If something has gone wrong that caused a patient’s death or such severe harm that the patient is unlikely to regain consciousness or capacity, the Healthcare Professional must be open and honest with those close to the patient. Time will need to be taken to convey the information in a compassionate way with the opportunity to ask questions at the time and afterwards (NMC & GMC Guidance 2015). We know from recent discussions that staff can find these open conversations difficult and a Trust-wide training programme to support staff is to be made available.

If the patient has died in our care, respect and sensitivity is needed for the wishes of the bereaved family/carers. Additionally, the wishes and plans of the deceased must also be taken into account if they are known.

**It is important to remember that Confidentiality does not die with the patient, any specific requests the patient made when alive have to be respected in death.**
Appropriate support and assistance should be offered to the bereaved family or carer, for example informing them where and how they can get help from the Chaplaincy and Funeral Directors.

**4.5 Being open and honest with patients about near misses**

If a near miss has occurred, the patient may wish for a change of team or Responsible Medical Officer or Care Coordinator, this should be respected.

**4.6 Encouraging a learning culture by reporting errors**

Being open, honest and candid relies on staff and your rigorous reporting of patient safety incidents. If something has gone wrong with the patient’s care and treatment it is vital that it is reported at an early stage so that lessons can be learnt. Patients must be protected from future harm and the Trust’s Incident reporting policy should be followed.

CQC Regulation 20: Duty of Candour reinforces a culture of openness and transparency within the NHS and other care organisations. Staff, services and the Trust as a whole will strive to learn from each and every mistake and untoward occurrence. The key ways in which this learning will take place are through a ‘Just Culture’, one to one supervision, debriefings and the root cause analysis undertaken following Serious Incidents, learning from these incidents and then rolling out good practice.
## 5 Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Apology</td>
<td>An expression of regret and saying sorry meaningfully when something has gone wrong.</td>
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<tr>
<td>Candour:</td>
<td>Candour is about openness, honesty, truthfulness and sincerity. ‘Any service user harmed in the receipt of care or treatment is informed of the facts of what has happened, offered an appropriate remedy to put it right and support regardless of whether a complaint has been made or a question asked’ (Francis 2013).</td>
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<tr>
<td>Complaint</td>
<td>Is the expression of dissatisfaction verbally or in writing, directly or on behalf of a service user, their family and or carer.</td>
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<td>Just Culture</td>
<td>Staff, patients and carers are treated fairly with empathy and consideration when they been involved in a patient safety incident or have raised a safety issue.</td>
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<tr>
<td>Openness:</td>
<td>Enabling concerns, questions and complaints to be raised and disclosed without fear and for these to be answered.</td>
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<tr>
<td>Notifiable Safety Incidents:</td>
<td>Is any unintended or unexpected incident that could have or did lead to harm for a patient we provide care and treatment (regulated activity) to, and categorised as:</td>
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<tr>
<td></td>
<td>- <strong>No harm (near miss)</strong>&lt;br&gt;A patient safety incident that had the potential to cause harm but was prevented resulting in no harm, loss or damage.</td>
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<td></td>
<td>- <strong>Low Harm (minimal harm)</strong>&lt;br&gt;This reflects a patient safety incident that resulted in a minor or undesirable outcome or no serious outcome.</td>
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<td></td>
<td><strong>AND</strong></td>
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<tr>
<td>Duty of Candour</td>
<td>When something goes wrong with the patients care and treatment because of something we should or should not have done and resulted in <strong>Moderate or severe harm or death results.</strong></td>
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<tr>
<td></td>
<td>- <strong>Moderate Harm (short term harm)</strong>&lt;br&gt;The patient safety incidents are moderately serious in nature or consequence that lead to a moderate increase in treatment e.g. unplanned return to surgery, unplanned readmission, prolonged episode of care, extra time in hospital or as an outpatient, cancellation of treatment or transfer to another treatment are such as ICU.</td>
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<td></td>
<td>- <strong>Severe Harm (permanent or long-term)</strong>&lt;br&gt;Incidents that are serious in nature or consequence and may be reportable on the Strategic Executive Information System (STEIS)</td>
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<td></td>
<td>- <strong>Catastrophic Harm</strong> An Unexpected Death</td>
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<tr>
<td>Transparency:</td>
<td>Is to allow the truths relating to mistakes or errors that have happened to someone while in our care are shared with service users, the public and regulators.</td>
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6 Related documents

This document is to be read in conjunction with the Trust SUI Incident reporting:

Incident Reporting and Investigation Policy Corp/0043/v7(5)
CQC Regulation 20: Duty of Candour March 2015


7 How this policy will be implemented

- This policy will be published on the Trust's intranet and external website.
- Line managers will disseminate this policy to all Trust employees through a line management briefing.

8 How this policy will be audited

The policy and processes and procedures will be audited by the Clinical Effectiveness Team and external audit before the proposed review date of April 2018.

9 References


Allied Health Professionals:
http://www.hcpcuk.org/assets/documents/10004EDFStandardsofconduct,performanceandethics.pdf

NMC and GMC Duty of Candour Guidance: Openness and honesty when things go wrong

NHS Resolution Saying Sorry 2017
10 Appendix 1 - Duty of Candour Check List

Look at the incident and consider whether the harm has been caused during a regulated activity and ask yourself:

As a Healthcare Professional do I believe this harm may have resulted from actions, omissions or mistakes made in the course of this persons care and treatment (regulated activity)?

Was it an unintended OR unexpected incident (it can be either or and you don’t need for both to apply) that occurred during the provision of the patient's care and treatment (regulated activity) that could result in or appears to have resulted in:

- **Death of the patient** (the death must directly to the relate to the incident and not the natural course of the service users illness or underlying condition)
- **Severe Harm**
- **Moderate Harm** means a moderate increase in treatment AND significant harm
- **Prolonged psychological harm** (more than 28 days)

FOR DUTY OF CANDOUR TO APPLY THE INCIDENT MUST OCCUR IN THE PROVISION OF REGULATED ACTIVITY AND AT THE TIME IT ONLY NEEDS TO BE THE REASONABLE OPINION OF THE HEALTHCARE PROFESSIONAL AS TO WHETHER DUTY OF CANDOUR APPLIES.

The relevant person (the patient where appropriate or family/carer) must be NOTIFIED for each incident.

It is recognised that serious incidents can have a significant impact on staff involved or witness to the incident. They will want to know what happened and why and what can be done to prevent it happening again. Staff should have the opportunity to access professional advice from their relevant professional body or union, staff counselling and or Occupational Health services.

An early meeting with the relevant person must be held to explain what happened, why it happened, how it happened and what can be done to minimise it happening again to someone else i.e. action is being taken. Appropriate treatment and support should be provided for the patient, family and or carer; signposting to a suitable organisation, such as Healthwatch, PALS, AvMA or an independent advocate, and support with transport are examples of what can be done.

In line with the Duty of Candour where possible the relevant person needs to be made aware as soon as possible in person and in writing of the process of review, a meeting to express concerns, an opportunity to inform the Terms of Reference and how they will be able to contribute to the review process and be given access to the findings. Where appropriate in incidents of death or severe harm this will involve the Patient Safety Team Reviewer.
# Death of a patient - Duty of Candour

<table>
<thead>
<tr>
<th>Where appropriate and in line with the patient’s wishes when alive:</th>
<th>Y/N</th>
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<tbody>
<tr>
<td>A registered Healthcare Professional immediately notifies the relevant person and offers condolences (‘I am very sorry for your loss and or I am sorry about what has happened’)</td>
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<tr>
<td>If the relevant person cannot be contacted or doesn’t want to be involved this must be recorded in the case notes on Paris</td>
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<tr>
<td>Offer the relevant person a face to face meeting to explain facts known at the time and what will happen next i.e. a review of the care and treatment and that they can be involved in the review</td>
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<tr>
<td>Complete a DATIX as soon as practicable and inform the Head of Service</td>
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<tr>
<td>Record the incident as well as actions taken for Duty of Candour in case notes on Paris, you must include the date the apology is given (this is classed a permanent record for Duty of Candour)</td>
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<tr>
<td>The Head of Service will formalise this and write to relevant person and formally offer condolences and offering a face to face meeting to explain facts and inform what happens next, as well as to offer an apology and the opportunity to be involved in review process of what happened</td>
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<tr>
<td>Save all Duty of Candour letters on PARIS in letters and record in case notes on PARIS the letter has been sent and to and by whom; copy of the letter to Patient Safety Inbox <a href="mailto:Tewv.patientsafety@nhs.net">Tewv.patientsafety@nhs.net</a></td>
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## Severe Harm

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<tr>
<td>A registered Healthcare Professional immediately notifies relevant person about the incident informing them of any short or long term effects and all facts known to that point, any remedy and what happens next i.e. a review of the care and treatment and that they can be involved</td>
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<tr>
<td>Offer a verbal apology (‘I am really sorry’) and offer reasonable support and stay with the patient where this is what the patient wants and is appropriate</td>
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<tr>
<td>Offer a written apology; record in case notes on PARIS when it is sent and in letters</td>
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<tr>
<td>Record full details of incident and Duty of Candour actions taken on PARIS, you must record the date the apology is given (classed as a permanent record)</td>
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<tr>
<td>Complete DATIX as soon as practicable.</td>
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## Moderate level of harm

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<tr>
<td>A registered Healthcare Professional immediately notifies the relevant person in a face to face meeting what has happened explaining any long and short term effects known and any remedy: with all facts known to that point, and what happens next i.e. a review of the care and treatment and that they can be involved</td>
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<tr>
<td>Offer a verbal apology (‘I am really sorry’) and offer to follow this up in writing, record on PARIS when it is sent and also offer reasonable support from the team</td>
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<tr>
<td>Record all Duty of Candour actions in case notes on PARIS, you must record the date the apology is given (classed as a permanent record) include Incident details, names of those present, who explained what happened and offer the apology</td>
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<tr>
<td>Complete a DATIX as soon as practicable.</td>
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<tr>
<td>Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.</td>
<td>Corporate</td>
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<tr>
<td>------------------------------------------</td>
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</tbody>
</table>
| Name of responsible person and job title | Jennifer Illingworth  
Director of Quality Governance |
| Name of working party, to include any other individuals, agencies or groups involved in this analysis | Duty of Candour working group |
| Policy (document/service) name | Duty of Candour Policy: being open, honest and transparent |
| Is the area being assessed a; | Policy/Strategy ✓  
Service/Business plan  
Procedure/Guidance  
Code of practice  
Other – Please state |
| Geographical area | Trustwide |
| Aims and objectives | This policy informs all Trust staff of their roles and responsibilities relating to the Duty of Candour and culture of candour about being open, honest and transparent with patients, carers and or families and giving an apology should something go wrong with the care and treatment we provide. This includes something that causes or has the potential to cause harm or distress.  
This policy, as well as informing staff of their role in relation to Duty of Candour and culture of candour informs service users, relatives and carers of what they can expect from the Trust and the professionals involved if something goes wrong with the care and treatment we have provided. |
The purpose of this policy is to set out the Trust's expectation for all healthcare professionals' professional responsibility to be honest with patients if things go wrong. This includes Regulation 20: Duty of Candour and 'The Professional Duty of Candour' (Openness and Honesty when things go wrong, NMC and GMC 2015).

The core objectives of this policy are to ensure that:

- All Trust staff are aware of CQC Regulation 20: Duty of Candour and the culture of candour and what to do should something go wrong with a patient's care and treatment.
- Service users/patients and their family or carers have the Duty of Candour and or culture of candour applied if something goes wrong with the care and treatment we provided and are given appropriate support.
- That 'saying sorry' is a genuine and meaningful communication preferably in person unless asked otherwise by the patient (family or carer).

| Start date of Equality Analysis Screening (This is the date you are asked to write or review the document/service etc.) | 4th October 2016 |
| End date of Equality Analysis Screening (This is when you have completed the analysis and it is ready to go to EMT to be approved) | 17th October 2016 |
1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?

All staff in the Trust working in clinical services, especially medics, Registered Nurses and Allied Health Professionals.

2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?

<table>
<thead>
<tr>
<th>Category</th>
<th>Race (including Gypsy and Traveller)</th>
<th>Disability (includes physical, learning, mental health, sensory and medical disabilities)</th>
<th>Gender (Men, women and gender neutral etc.)</th>
<th>Age (includes, young people, older people – people of all ages)</th>
<th>Religion or Belief (includes faith groups, atheism and philosophical belief’s)</th>
<th>Pregnancy and Maternity (includes pregnancy, women who are breastfeeding and women on maternity leave)</th>
<th>Marriage and Civil Partnership (includes opposite and same sex couples who are married or civil partners)</th>
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</thead>
<tbody>
<tr>
<td>Race (including Gypsy and Traveller)</td>
<td>No</td>
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<td>Bisexual and Heterosexual etc.)</td>
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</table>

Yes – Please describe anticipated negative impact/s
No – Please describe positive impacts/s

No, it will ensure every patient involved in any kind of patient safety incident is treated the same.

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.?

Yes
### Sources of Information may include:

- Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc.
- Investigation findings
- Trust Strategic Direction
- Data collection/analysis
- National Guidance/Reports
- NMC and GMC guidance
- Allied Health Professionals guidance
- Staff grievances
- Media
- Community Consultation/Consultation Groups
- Internal Consultation
- Research
- Other (Please state below)

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4. **Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership**

**No** – Please describe future plans that you may have to engage and involve people from different groups

The plan is to go to Triangle of Care Forums held in the different localities to engage with carers and service users.

5. **As part of this equality analysis have any training needs/service needs been identified?**

**Yes/No**

Please describe the identified training needs/service needs below

Workshops on Duty of Candour were held around the Trust when Regulation 20: Duty of Candour was first launched. Information on this is available.
A training need has been identified for:

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<th></th>
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<td>Trust staff</td>
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<tr>
<td>Service users</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Contractors or other outside agencies</td>
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</tbody>
</table>

Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so.

The completed EA has been signed off by:

You the Policy owner/manager:

Type name: Anne Lowery, Head of Compliance  
Date: 17/10/2016

Your reporting (line) manager:

Type name: Jennifer Illingworth, Director of Quality Governance  
Date: 17/10/2016
## 11 Document control

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<th>Date of approval:</th>
<th>02 November 2016</th>
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<td>Next review date:</td>
<td>02 February 2020</td>
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<tr>
<td>This document replaces:</td>
<td>This is a new policy</td>
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### Lead:
- Name: Anne Lowery
- Title: Head of Compliance

### Members of working party:
- Name: Catherine Lee Cowan
- Title: Head of Patient Safety
- Name: Cath Crawford
- Title: Modern Matron
- Name: Michelle Parkes
- Title: Modern Matron
- Name: Lorraine Ferrier
- Title: Head of Nursing
- Name: Lesley Munshi
- Title: Patient Safety Investigator
- Name: Jan Bartlett
- Title: Patient Safety Investigator

### This document has been agreed and accepted by:
- Name: Jennifer Illingworth
- Title: Director of Governance

### This document was ratified by:
- Name of committee/group: Executive Management Team
- Date: 02 November 2016

### An equality analysis was completed on this document on:
- Date: 17 October 2016

### Change record

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<td>02 Nov 2016</td>
<td>New document</td>
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<tr>
<td>1.1</td>
<td>26 Apr 2017</td>
<td>Amended in line with Audit One recommendations to strengthen Moderate Harm</td>
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<td>1.1</td>
<td>12 Aug 2019</td>
<td>Review date extended from 02 Nov 2019 to 02 Feb 2020</td>
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