# Duty of Candour Policy

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| **Version** | V5.0 |
| **Supersedes:** | V4.0 |
| **Date Ratified by Board:** | 25.05.2017 (Original) |
| **Reference Number:** | PC24POL103 |
| **Title & Department of originator:** | Director of Quality & Patient Safety |
| **Title of responsible committee/department:** | Quality & Patient Safety |
| **Effective Date:** | August 2021 |
| **Next Review date:** | August 2022 or when there is a change in Policy. |
| **Target audience:** | All employees, including all Health Care Professionals |
| **Impact Assessment Date:** | 05.05.2017 |
| **Summary** | The purpose of this policy is to provide advice on communicating with patient's, relatives and/or their representatives, following harm or potential harm so that PC24 can ensure that communications to patients, carers, service users and the public are open, honest and transparent. |

| Version | Date | Control Reason | Title of Accountable Person for this Version |
|---|---|---|---|
| V1.0 | 09/2016 | New Policy.<br>This document originated from North West Ambulance Service, in line with the partnership arrangements to implement the NHS111 service and has been adapted and adopted for use within Primary Care 24. | Quality and Patient Safety Lead |
| V2.0 | 20.01.2017 | Policy subject to review within the first year, amended to meet requirements of policy on policy management policy. To include equality impact screening | Associate Director for Quality & Patient Safety |
| V3.0 | 31.1.2018 | Policy review after one year, minor changes to reflect regulation 20 CQC Duty of Candour.<br>Titles of staff grade changes, additional changes to the training programme | Associate Director of Nursing |
| V4.0 | 18.12.2019 | Logo changes and Primary Care 24 changed to Primary Care 24 throughout the document. | Director of Nursing |

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|---|---|---|---|
| V5.0 | 14/07/2021 | Policy review | Interim Deputy Director of Nursing |

| Reference Documents | Electronic Locations (Controlled Copy) | Location for Hard Copies |
|---|---|---|
| See Section 16 for a full list of references. | Primary Care 24 Intranet / Policies & Guidance/Governance & Risk | Policy File, Wavertree Headquarters |

| Consultation: Committees / Groups / Individual | Date |
|---|---|
| **SMT, Policy Group, Quality & Workforce Committee, Board** | **25.05.2017** |

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## 1 INTRODUCTION

The duty of candour is a general duty to be open and transparent with people receiving care from healthcare providers. It applies to every health and social care provider that CQC regulates.

Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. It involves apologising and explaining what happened to patients who have been harmed as a result of their healthcare treatment. It ensures communication is effective, open, and honest and occurs as soon as possible following an incident.

The duty of candour requires registered providers and registered managers (known as 'registered persons') to act in an open and transparent way with people receiving care or treatment from them. The regulation also defines 'notifiable safety incidents' and specifies how registered persons must apply the duty of candour if these incidents occur. https://www.cqc.org.uk/node/5593 Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

## 2 PURPOSE

Primary Care 24's (PC24) first priority is to deliver safe, caring and effective care to patients. The purpose of this policy is to provide advice on communicating with patient's, their relatives and/or their representatives, following harm so that PC24 can ensure that communications to patients, carers, service users and the public are open, honest and transparent.

The framework is set to promote a culture of good practice around the processing of information and use of information systems that supports the provision of high quality care to our service users. The organisation seeks to develop a safety culture which has at its core the principle of being open. This includes all forms of communication,

at all levels regarding an incident where a member of staff, patient, carer or the public has been harmed by PC24.

'Being Open' is a set of ten principles (Appendix 1) that healthcare staff use when communicating with patients, their families/carers and fellow healthcare staff following a safety incident in which an individual was harmed. 'Being Open' involves acknowledging, being truthful, apologising, recognising patient expectations, professionalism, improving risk management systems, taking a multidisciplinary approach to responsibility, clinical governance, confidentiality and continuity of care.

A full explanation is required when things go wrong. This also involves conducting a thorough investigation into the incident and reassuring the patient, their families/carers and our staff that lessons that have been learned will help prevent the incident recurring. At the same time, it is important to provide support for those involved to cope with the physical and psychological consequences of what happened.

## 3 SCOPE

Duty of candour applies to all cases of Serious Incident resulting in harm in healthcare and adult social care. The duty also applies in cause of death, if the death relates to the incident of harm rather than natural cause of the service user's illness of underlying condition.

The PC24 Management of Incidents and Serious Incident policy requires staff to report all safety incidents, including those where there was no harm, low harm or it was prevented, or a near miss.

Incidents that score as no harm or low harm or near miss **do not** have to be dealt with using this policy.

**Notifiable safety incidents**

‘Notifiable safety incident’ is a specific term defined in the duty of candour regulation. It should not be confused with other types of safety incidents or notifications. A notifiable 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 regulated by CQC.
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.

This element varies slightly depending on the type of provider. The definitions of harm vary because when the regulation was written, harm thresholds were aligned with existing notification systems to reduce the burden on providers.

**Statutory and professional duties of candour**:

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. CQC regulate the statutory duty, while the professional duty is overseen by regulators of specific healthcare professions such as the General Medical Council (GMC), Nursing and Midwifery Council (NMC) and the General Dental Council (GDC). The statutory duty also includes specific requirements for certain situations known as ‘notifiable safety incidents’. If something qualifies as a notifiable safety incident, carrying out the professional duty alone will not be enough to meet the requirements of the statutory duty.

Saying sorry is not admitting fault A crucial part of the duty of candour is the apology. Apologising is not an admission of liability. This is the case, regardless of whether you are in the health or social care, or public or private sectors. In many cases it is the lack of timely apology that pushes people to take legal action. To fulfil the duty of candour, you must apologise for the harm caused, regardless of fault, as well as being open and transparent about what has happened.

NHS Resolution is the organisation that manages clinical negligence claims against the NHS. Their 'Saying Sorry' leaflet confirms that apologising will not affect indemnity cover:

"Saying sorry is:

- always the right thing to do
- not an admission of liability
- acknowledges that something could have gone better
- The first step to learning from what happened and preventing it recurring.

**Paragraph 9 of Regulation 20 defines harm** as:

In the reasonable opinion of a healthcare professional, could result in or appears to have:

- Resulted in the death of the person - directly due to the incident, rather than the natural course of the person's illness or underlying condition
- The person experiencing a sensory, motor or intellectual impairment that has lasted, or is likely to last, for a continuous period of at least 28 days
- Changes to the structure of the person's body
- The person experiencing prolonged pain or prolonged psychological harm, or a shorter life expectancy for the person using the service.

These definitions of harm are aligned to CQC's notification system for reporting deaths and serious injuries. (Definitions of harm – Appendix 3)

## 4 RESPONSIBILITIES

### 4.1 Board

The Chair, Chief Executive and all members of the Board endorse the principles of Duty of Candour & Being Open and encourage the open reporting of all incidents. Through the subsequent detailed investigations, the organisation can learn from incidents. The Board is committed to actively promoting an open, honest and fair culture.

Board and senior managers have a crucial role to play. Duty of Candour & Being Open must not be seen as an 'add on' when something goes wrong, but should be at the core of the organisation's values and culture of working with patients/service users, the public and staff.

### 4.2 Deputy Directors, Service Delivery Unit Leads/ Heads of Services

The above staff will actively promote an open and fair culture that fosters peer support and discourages the attribution of blame. They will work towards a culture where human error is understood to be a consequence of flaws in the healthcare systems, not necessarily the individual, they will:

- Educate all their healthcare staff about Duty of Candour and ensure they understand that apologising to patients/service users, their families and carers is not an admission of liability.
- Provide facilities for formal and informal debriefing of the clinical team involved in the patient safety incident, where appropriate, as part of the support system, and to be separate from the requirement to provide statements for the investigation. Staff may also benefit from individual feedback about the final outcome of the patient/service user safety incident investigation.
- provide opportunities within the clinical schedule for staff involved in the Duty of Candour process to discuss their involvement and/or the circumstances leading up to the patient/service user safety incident and what they are going to say.

**4.3** All employees have a responsibility to:

- Tell someone if you have been involved in and/or observed where a patient may have been or had the potential to be harmed by something not being done.
- Report the actual and or potential incident via PC24'S incident reporting process using Datix, see appendix 2 for the grading of incidents.
- Inform others and allow for a level of investigation to take place to identify the how, what, why and when?
- Learn lessons by taking action and/or contributing supporting the implementation of recommendations.

## 5 DUTY OF CANDOUR REGULATIONS

The regulations outline that, where the harm threshold has been breached, specific reporting requirements must be followed. In summary, PC24 needs to:

a. Notify the relevant person that the incident has occurred and provide reasonable support to the relevant person
b. Notification be given in person by one or more members of staff, although there may be exceptions where it is not possible to notify the relevant person in person.
c. This notification must be followed up in writing to the relevant person within 10 working days of the incident being reported or sooner where possible
d. Provide an account of all the facts known about the incident to date
e. Advise the relevant person what further enquiries into the incident will be undertaken and by whom
f. Include an apology and/or a sincere expression of regret, and;
g. Be recorded in writing in the notes/records

### 5.1 What led to the Duty of Candour?

**5.1.1** The Francis 2 Report 2013 (following on from the first published Francis Report of 2010) tells the story about the appalling suffering of many patients at the Mid Staffordshire Hospital.

**5.1.2** The report highlighted the serious failure on the part of a provider Trust Board who did not listen sufficiently to its patients and staff or ensure the correction of deficiencies were brought to the Trust's attention.

**5.1.3** Above all, it failed to tackle a deceptive negative culture which involved a tolerance of poor standards and a detachment from managerial/leadership responsibilities.

**5.1.4** The failure was, in part, the consequence of allowing a focus on achieving national access targets, achieving financial balance and seeking Foundation Trust status, at the cost of delivering acceptable standards of care.

**5.1.5** The story continued as the checks and balances which should have prevented serious systemic failure of this sort including agencies, scrutiny groups, commissioners, regulators and professional bodies also failed.

## 6.0 RECOMMENDATIONS FROM THE FRANCIS REPORT

The Francis Inquiry concluded that there seems to be a near universal agreement that candour is an essential component in high quality healthcare, but the openness, transparency and candour are frequently not observed. The Report recommendations about the Duty of Candour are summarised below:

**Recommendation 181 - A Statutory Duty of Candour;**

- On healthcare providers who believe/suspect treatment or care provided by it to a patient has caused death/serious injury to a patient to inform that patient

or other duly authorised person as soon as practicable and thereafter to provide such information and explanation as the patient may reasonably request.

- On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable.
- It should be a criminal offence for any registered medical practitioner, nurse, allied health professional, or director of an authorised or registered healthcare organisation to knowingly obstruct another in the performance of these statutory duties, provide information to a patient or nearest relative with the intent to mislead them about such an incident or dishonestly make an untruthful statement to a commissioner or regulator, knowing or believing that they are likely to rely on the statement in the performance of their duties.

**Recommendation 183 – A Criminal Offence**

For any Registered Medical Practitioner, Nurse, Allied Health Professional or Director to:

- Knowingly obstruct another in these statutory duties
- Provide information to a patient intending to mislead them
- Dishonestly make an untruthful statement to a Commissioner or Regulator knowing or believing that they are likely to rely on it in the performance of their duties.

**Care Quality Commissions approach to the duty of Candour Regulation 20**

The CQC's approach to the duty of candour is part of their new regulatory approach. Regulation 20: Duty of Candour applies to each type of service registered with CQC. Regulation 20 applies to providers when they are providing care and treatment to people who use services in the carrying on of a regulated activity only.
To meet the requirements of Regulation 20, a registered provider has to:

• Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity.

## 7 PC24 ADHERENCE TO THE DUTY OF CANDOUR

The responsibility for creating a culture or reporting and learning arises from leadership and encourages staff to tell patients when things have gone wrong. This applies to incidents resulting from moderate/severe harm or death (not necessarily none or low harm, unless it is deemed appropriate by PC24).

Refer to Appendix 3 for the PC24 Duty of Candour Action Card and Appendix 4 for the PC24 Duty of Candour Procedure.

PC24 will ensure that:

- The patient, family and/or patient representative are informed within 10 working days of PC24 being aware of the incident
- The initial notification must be verbal and accompanied with an offer of a written notification.
- The patient and their family and/or representative are supported to deal with the consequences and have a key contact identified for the incident.
- There is an appropriate level of investigation/root cause analysis.
- An apology is provided with a record of this being completed.
- A step by step explanation is offered as soon as possible pending the investigation and then regularly updated.
- A full written documentation of all meetings is completed and kept with the patient, family and/or patient representative and recorded on the PC24 Datix Incident Reporting system.
- Full written documentation of all staff interviews and meetings about the incident are completed and recorded on PC24 Datix Incident Reporting system.

- The findings of the investigation report will be shared with the patient, family and/or patient representative.
- The final investigation report, using the results of the investigation, will also include information on how lessons are learned to help prevent the incident recurring.
- Reports are provided to the PC24 Commissioners, as requested.

## 8 FAILURE TO MEET THE STANDARDS REQUIRED FOR THE DUTY

Primary Care 24 are required to inform the Care Quality Commission (CQC) and its Commissioners of failure to comply with its CQC registration requirements.

## 9 SUPPORTING STAFF

PC24 acknowledges that an employee may find the process of Duty of Candour stressful and recognises it is therefore important that employees – as stakeholders in the process – are appropriately supported. This applies to all employees. This policy includes the specific duties and responsibilities for all employees at all levels of the organisation.

All employees involved in a traumatic or stressful event must inform their manager if:

- They are experiencing difficulties associated with the situation or as a result of the requirement to act as a witness, in order to enable their line manager to support them directly
- They are experiencing difficulties and would like to be referred to the relevant support services
- Time is required away from the workplace to attend any meetings associated with the incident or, where required, to attend for counselling or support.

## 10 TRAINING

Please refer to the attached Training Needs Analysis in Appendix 5.

## 11 MONITORING AND COMPLIANCE

The Quality and Patient Safety Department are responsible for monitoring compliance with this policy every 12 months or sooner to ensure that staff are meeting the policy requirements. The following performance measures will be used:

| Element | Lead | Tool | Frequency |
|---|---|---|---|
| Whether Duty of Candour was applied comprehensively, e.g. was apology given; was written notification provided; was outcome of investigation shared with patient/representative | Director of Nursing | Datix | Monthly via reports |
| Was the learning acted upon and shared across PC24 | Director of Nursing | Action Plans & Datix | Reporting to SDU meetings & Quality & Workforce Committee |
| Process for encouraging open communication amongst staff | Director of Nursing | Datix and Whistleblowing Policy | Submission of reports to various committees |

## 12 IMPLEMENTATION

This Policy will be implemented via the document owner with the support of the Service Managers and any relevant Committees.

The document owner will outline the plan for implementation in conjunction with the production of the policy (Appendix 6). Training needs should be assessed and identified.

On approval of the policy it will be uploaded onto the staff intranet, this will be supported by a message through PC24's newsletter, NEWS24. The Quality & Patient Safety team will be responsible for this action.

## 13 EQUALITIES AND HEALTH INEQUALITIES STATEMENT

PC24 is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy has been implemented with due regard to this commitment. To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact analysis conducted where necessary. PC24 will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

## 14 PERSONAL INFORMATION STATEMENT

PC24 is committed to an environment that protects personal information aspects in the development of any policy. When proposing change there is a new requirement for policy writers to investigate when the personal information aspect of the policy complies with the data protection principles in Schedule 1 of the Data Protection Act 1998. All individuals with responsibility for reviewing/writing policies should consider Privacy Impact Assessment compliance.

This policy complies with the Data Protection Act 1998, therefore no Privacy Impact Assessment is necessary.

## 15 ASSOCIATED PC24 DOCUMENTS

- PC24 Incident & Serious Incident Management Policy PC24POL32
- PC24 Policy for Policy Management PC24POL43

- PC24 Complaints, Concerns and Compliments Policy PC24POL34
- PC24 Confidentiality, Data Protection & Caldicott Policy PC24POL1
- PC24 Whistleblowing Policy PC24POL102

## 16 SUPPORTING REFERENCES

The Health & Social Care Act 2008. Available at:
http://www.legislation.gov.uk/ukpga/2008/14/contents

CQC Regulation 20: Duty of Candour. Available at:
http://www.cqc.org.uk/content/regulation-20-duty-candour

NPSA Being Open Framework. Available at:
http://www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726

2009 Duty of Candour Framework NPSA – Saying sorry when things go wrong.

Regulation 20: Duty of candour
Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare March 2015

## 17 APPENDICES

### Appendix 1 10 Principles of Being Open

The following principles underpin *Being Open.*

## Appendix 2 PC24 Grading of Incidents

The grading of incidents will be calculated using the grading system below.

Root Cause Analysis techniques will be used to uncover the underlying causes of a patient safety incident.

| Severity | Definition |
|---|---|
| **1. Insignificant** | Has potential to cause harm but the impact was prevented/injury or illness not requiring intervention. Sing resolvable problem in patient experience. Resolvable system problem. |
| **2. Minor** | Minor injury or ill health – first aid or self-treatment – no incapacity. Patient experience temporarily unsatisfactory – rapidly resolved. Partial, resolvable failure of system. |
| **3. Moderate** | Significant injury or ill health – medical intervention necessary – some temporary incapacity. Patient outcome or experience below reasonable expectation in one or a number of areas. Partial, resolvable failure of system. |
| **4. Major/Severe** | Major injuries or long term incapacity or disability. Patient outcome or experience significantly below reasonable expectation across the board. Partial failure of critical system or project. Failure of important system or project. Multiple justified complaints. |
| **5. Catastrophic** | Death or major and permanent incapacity disability |

## Appendix 3 Definition of harm

These definitions of harm are aligned to CQC's notification system for reporting deaths and serious injuries.

Definitions of harm: These definitions are common to all types of service.

**Moderate harm**:

Harm that requires a moderate increase in treatment and significant, but not permanent, harm.

**Severe harm**:

A permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.

**Moderate increase in treatment**:

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)

**Prolonged pain**.

Pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

**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.

**Identifying a notifiable safety incident**

The presence or absence of fault on the part of a provider has no impact on whether or not something is defined as a notifiable safety incident. Saying sorry is not admitting fault. Even if something does not qualify as a notifiable safety incident, there is always an overarching duty of candour to be open and transparent with people using services.

## Appendix 4
## PC24 Duty of Candour Action Card

1. Recognise that a level 3, 4 or 5 patient harm incident has occurred.

   All safety incidents must be acknowledged, reported on Datix and escalated when they are identified. If a patient, carer, member of the public and/or member of staff report something untoward, it must be taken seriously and concerns treated with compassion. Denial of a patient's concern will make future open and honest communication increasingly difficult.

2. Establish an Investigating Manager/Officer as a single point of contact for the patient, family and/or patient representative and who is familiar with PC24 'Duty of Candour' Procedure. Conflicting information from different members of PC24 staff must be avoided as it could lead to confusion and distress.

   The patient will receive clear unambiguous information by the Investigating Manager/Officer as soon as practically possible. The information must be given in a truthful and open manner and be based purely on the facts known at the time and as new information emerges, they will be kept up to date. This single point of contact must be provided for any questions or requests the patient may have.

3. Ensure the nominated single point of contact is familiar with the 10 principles of 'Being Open'. A letter of acknowledgment (Appendix 8) to be issued to maintain an audit trail of DOC.
4. Make arrangements to speak with the patient, family and/or patient representative within 10 days of PC24 recognising that a level 3/4/5 patient harm incident has occurred.

5. Liaise with quality and governance to ensure the written apology to the patient, family and/or patient representative that the incident has occurred.

   Patients will receive a sincere expression of sorrow or regret that the harm has resulted. Verbal apologies will be offered as soon as possible. A written apology will be written by the Chief Executive or nominated person clearly stating regret for the suffering and distress resulting from the incident and it will be sent to the patient and/or carer or member of staff.

6. Ensure and maintain confidentiality.

   Respect must be given to patients to ensure privacy and rights of confidentiality. The consent of the individual(s) involved must be sought prior to disclosure of any such information. Where consent to disclosure is refused, disclosure may be lawful if deemed justifiable in the public interest.

7. Speak with the patient, family and/or patient representative using the following guide:

   - Apologise that an incident has occurred and for what has happened. Patients will receive a sincere expression of sorrow or regret for the harm that has resulted. Verbal apologies will be offered as soon as possible.

   - If known at this stage, explain what went wrong and where possible, why it went wrong. Always tell the truth and stick to the known facts of the incident. Do not provide personal opinion or information which has not been verified or confirmed.

   - If known at this stage, explain what steps will be taken to prevent a re-occurrence of such an incident. Always tell the truth and stick to the known

facts of the incident. Do not provide personal opinion or information which has not been verified or confirmed.

- Provide an opportunity for the patient, family and/or patient representative to ask questions. Always tell the truth and stick to the known facts of the incident. Do not provide personal opinion or information which has not been verified or confirmed.

- Provide the patient, family and/or patient representative with the support that they require and make suggestions as to the sources of support available. Patients must be provided with support in a manner appropriate to their needs. This involves consideration of any special circumstances that can include the patient requiring additional support, such as an independent patient advocate. Information and support groups must be provided to the patient.

- Agree with the patient, family and/or patient representative on any future contact, updates and/or meetings, as appropriate.

- Ensure the patient, family and/or patient representative are made aware that PC24 will always provide a continuity of care.
  Patients are entitled to expect that they will continue to receive all the usual treatment in accordance with their clinical needs, continue to be treated with respect and compassion and should be reassured accordingly.

- Explain that the outcomes of the final investigation will be shared with the patient, family and/or patient representative within 10 days of it being approved using the template letter (Appendix 9).

8. Ensure that a separate documented record is kept which contains a complete and accurate record of all meetings and discussions, including the date and time of each entry, what the patient, family and/or patient representative have said/been told and a summary of any agreed actions.

9. Ensure the patient, family and/or patient representative has a written record of the above.

10. Ensure that a record of all events is kept on Incident reporting system.

11. Provide a step by step explanation to the patient, family and/or patient representative, as soon as possible, pending the investigation.

12. Provide regular updates, to the patient, family and/or patient representative, as appropriate.

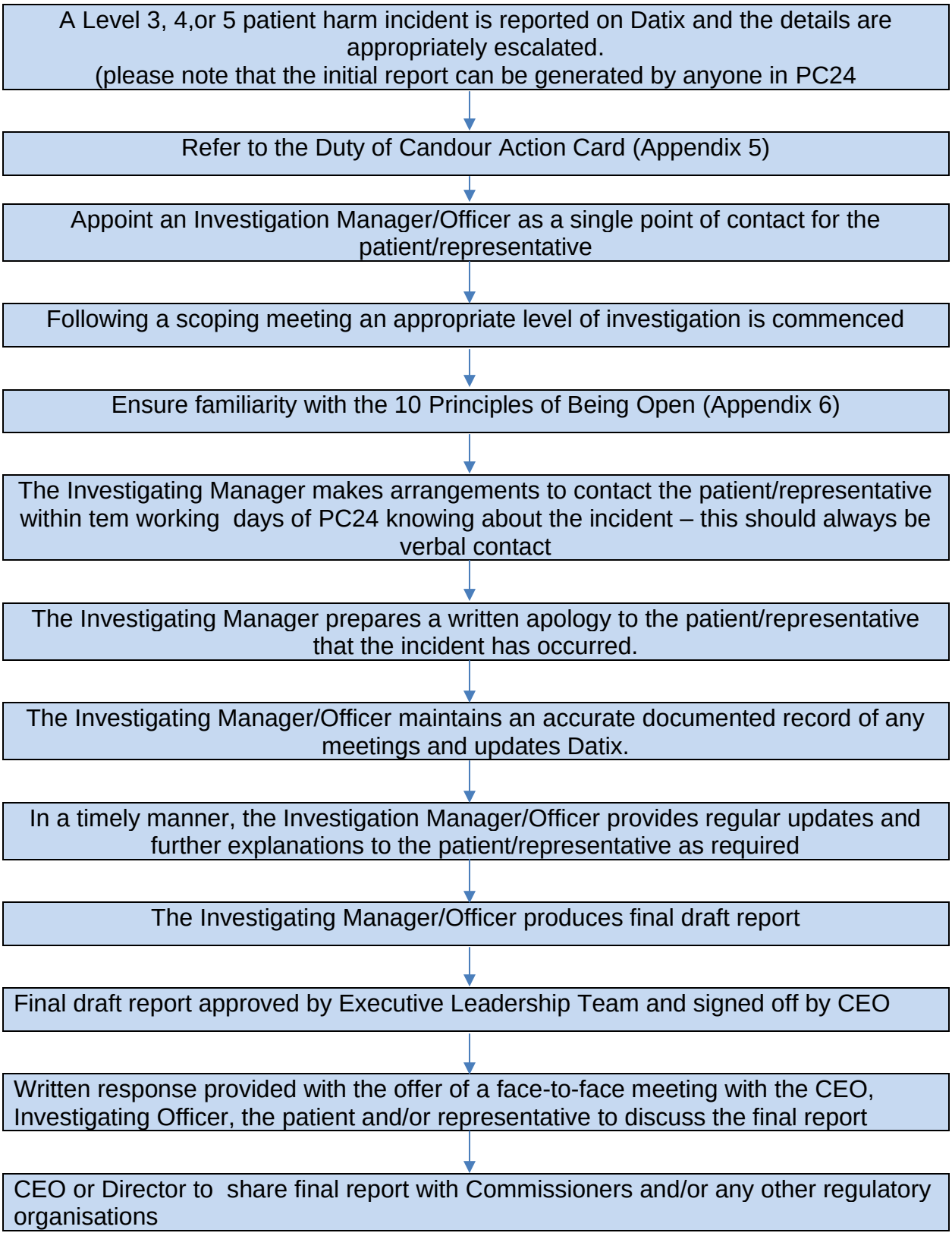
13. Prepare a final written report which is then approved via PC24 Governance arrangements.

14. Where acceptable, arrange a face to face meeting with the patient, family and/or patient representative to discuss the final incident report.

15. Share the approved final written report with the patient, family and/or patient representative, within 10 days of approval.

16. Ensure that approved final written reports are shared with Commissioners, as appropriate.

## Appendix 5 Duty of Candour Procedure



## Appendix 6 Training Needs Analysis

| Training Programme | Course Length | Frequency | Delivery Method | Staff Group | Recording Attendance | Strategic & Operational Responsibility |
|---|---|---|---|---|---|---|
| Root Cause Analysis Training | 1 day | Once only | Classroom, followed by mentorship, supervision | Senior staff who have a responsibility to carry out investigations for moderate/severe incidents within the Duty of Candour Policy | Attendance is recorded on the Training database | Director of Nursing |
| Risk awareness, reporting, escalation, risk assessment<br>Policy Implementation. | 3 hours<br>2 hours | Once only<br>Once only | Classroom<br>One – one ,small group, classroom, include | All staff groups<br>All staff groups | Attendance and evaluation recorded on training database<br>NA | Director of Nursing<br>Heads of service |

## Appendix 7 Implementation Plan

| Question | Response | Additional resources If so identify | Timescale |
|---|---|---|---|
| Who does the policy affect | All PC24 employees | Nil | Policy to be launched following Board Approval |
| What additional Standard Operating Standard Operating Procedures or forms need to be included in the policy | As outlined in section16 | Nil | As above |

| | | | |
|---|---|---|---|
| What is the proposed date of implementation | April 2017 or sooner | Nil | As above |
| Is training required | Refer to TNA embedded in document. | Nil | |
| If so what training is required (attach separate training outline) | Refer to TNA embedded in document. | Nil | |
| Who will facilitate the training | Quality & Patient Safety Team | Nil | |
| What audit processes have been identified | Refer to Monitoring and Compliance within the document. | Nil | |

## Appendix 8

Appendix 8 – Draft letter to follow the initial DOC notification discussion

Our ref:

Date

**Private and Confidential**

(insert name and address)

Dear

I am writing to follow up on the conversation that we had on (insert date) and to enclose a record of our discussion.

Again, I would like to express my sincere apologies that you have/your … has been involved in [provide appropriate factual details of patient safety incident here].

I would like to assure you that PC24 aims to provide a high quality service to all our patients. As explained, we are therefore undertaking a full investigation into you/your …'s care and treatment in an effort to understand exactly what happened and, at the conclusion of that investigation, we would like the opportunity to discuss this with you and share our findings.

The initial investigation will take up to xxxx weeks to complete and there may be a number of actions that arise out of the investigation. If we require more time to complete our investigation, we will ensure that you are kept informed.

As discussed, there may also be additional information that comes to light as the investigation proceeds and we have agreed [outline the agreed process] to ensure that you are kept informed.

When our investigation is completed, we will write to you again to ask how you would like us to provide feedback regarding the outcome, at a mutually convenient time and location.

XXXXX is acting as your lead contact for the duration of the investigation and they can be contacted on telephone number xxxxx xxxxxxx, email xxxxxxxx or at the address at the top of this letter.

I also recognise that you may not feel that any further communication would be of any help; if this is the case I would be grateful if you could contact xxxxxxxxxxxx to let them know.

Just as importantly, if there is anything else you would like to mention at this stage to assist with the investigation then please do contact us.

Yours sincerely

Name and designation

## Appendix 9

Appendix 9 – Draft letter to follow up when the investigation is complete

Our ref:

Date
**Private and Confidential**

(Insert name and address)

Dear xxxxxxx

I am writing to let you know that we have now conducted our investigation into (give details of the notifiable patient safety incident).

Either [We have arranged to meet on (date & time) and the meeting has been planned to take place at (insert venue). I would be grateful if you could contact xxxxxxxxxxxxxxx on number xxxxxxxxxx or by email xxxxxxxxxx or at the address above to confirm that you are still able to attend.

Xxxxxxxxxx can also explain who would be present at the meeting. You may also wish to consider whether you would like to bring a friend or family member along with you.]

OR

[I would, therefore, like to invite you/your … to meet with me to discuss the findings of the investigation and learning from events and would be grateful if you would contact xxxxxxxxxx on number xxxxxxxx or by email xxxxxxxxxx or at the address above, so that we can organise an appropriate day, time and venue should you wish to meet. Xxxxxxxxxx can also explain who would be present at the meeting.

You may also wish to consider whether you would like to bring a friend or family member along with you.] If however you do not wish to attend a meeting, I can arrange for a summary of the investigation's conclusions and action plan to be sent directly to you.

Finally, I and the staff at PC24 are very sorry for any distress caused as a result of this incident.

Yours sincerely

Name
Designation

**Appendix 10**
**Equalities & Health Inequalities Screening**

# Equalities and Health Inequalities – Screening Tool

Name of Policy: Duty of Candour Policy

Date of Ratification: Original May 2017

Version number: V1.0

To be read in conjunction with Equalities and Health Inequalities Analysis Guidance, Quality & Patient Safety Team, Primary Care 24, 2016.

Prepared by: Quality & Patient Safety Team.

# 1 Introduction

The purpose of this Screening Tool is to help you decide whether or not you need to undertake an Equality and Health Inequalities Analysis (EHIA) for your project, policy or piece of work. It is your responsibility to take this decision once you have worked through the Screening Tool. Once completed, the Head of your SDU or the Quality & Patient Safety Team will need to sign off the Screening Tool and approve your decision i.e. to either undertake an EHIA or not to undertake an EHIA.

The Quality and Patient Safety Team can offer support where needed. It is advisable to contact us as early as possible so that we are aware of your project.

When completing the Screening Tool, consider the nine protected characteristics and how your work would benefit one or more of these groups. The nine protected characteristics are as follows:

1. Age
2. Disability
3. Gender reassignment
4. Marriage and civil partnership
5. Pregnancy and maternity
6. Race
7. Religion and belief
8. Sex
9. Sexual orientation

A number of groups of people who are not usually provided for by healthcare services and includes people who are homeless, rough sleepers, vulnerable migrants, sex workers, Gypsies and Travellers, Female Genital Mutilation (FGM), human trafficking and people in recovery. Primary Care 24 will also consider these groups when completing the Screening Tool:

The **guidance** which accompanies this tool will support you to ensure you are completing this document properly. It can be found at: http://extranet.Primarycare24.co.uk/

# 2 Equality and Health Inequalities: Screening Tool

| A | General information |
|---|---|
| A1 | Title: **Duty of Candour Policy**<br>What is the title of the activity, project or programme? |
| A2. | What are the intended outcomes of this work?<br>Please outline why this work is being undertaken and the objectives.<br>**Being Open is a set of principles that healthcare staff use when communicating with patients, their families/carers and fellow healthcare staff following a safety incident in which an individual was harmed. Being Open involves acknowledging, being truthful, apologising, recognising patient expectations, professionalism, improving risk management systems, taking a multidisciplinary approach to responsibility, clinical governance, confidentiality and continuity of care.**<br><br>**A full explanation is required when things go wrong. This also involves conducting a thorough investigation into the incident and reassuring the patient, their families/carers and our staff that lessons that have been learned will help prevent the incident recurring**. |
| A3. | Who will be affected by this project, programme or work? |

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| | Please identify whether the project will affect staff, patients, service users, partner organisations or others. **Direct impact on staff and an indirect impact on patient.** | | |
| **B** | **The Public Sector Equality Duty** | | |
| **B1** | Could the initiative help to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics (see above)? | | |
| | **Yes** | No | Do not know |
| | Summary response and your reasons: **Policy is directly applicable to staff If policy is followed, all patients will be treated the same.** | | |
| **B2** | Could the initiative undermine steps to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics? | | |
| | Yes | **No** | Do not know |
| | Summary response and your reasons: **If policy is followed, all patients will be treated the same.** | | |
| **B3** | Could the initiative help to advance equality of opportunity? If yes, for which of the nine protected characteristics? | | |
| | **Yes** | No | Do not know |
| | Summary response and your reasons: **If policy is followed, all patients will be treated the same.** | | |
| **B4** | Could the initiative undermine the advancement of equality of opportunity? If yes, for which of the nine protected characteristics? | | |
| | Yes | **No** | Do not know |
| | Summary response and your reasons: **If policy is followed, all patients will be treated the same.** | | |
| **B5** | Could the initiative help to foster good relations between groups who share protected characteristics? If yes, for which of the nine protected characteristics? | | |
| | **Yes** | No | Do not know |
| | Summary reasons: **If policy is followed, all patients will be treated the same.** | | |
| **B6** | Could the initiative undermine the fostering of good relations between groups who share protected characteristics? If yes, for which of the nine protected characteristics? | | |
| | Yes | **No** | Do not know |
| | Summary response and your reasons**:** If policy is followed, all patients will be treated the same. | | |
| **C** | **The duty to have regard to reduce health inequalities** | | |
| **C1** | Will the initiative contribute to the duties to reduce health inequalities? | | |
| | Could the initiative reduce inequalities in access to health care for any groups which face health inequalities? If yes for which groups? | | |
| | Yes | **No** | Do not know |
| | Summary response and your reasons: Policy applies directly to staff. | | |

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| **C2** | Could the initiative reduce inequalities in health outcomes for any groups which face health inequalities? If yes, for which groups? | | |
| | Yes | **No** | Do not know |
| | Summary response and your reasons: Policy applies directly to staff. | | |
| D | Will a full Equality and Health Inequalities Analysis (EHIA) be completed? | | |
| **D1** | Will a full EHIA be completed?<br>Bearing in mind your previous responses, have you decided that an EHIA should be completed? Please see notes. [1] Please place an X below in the correct box below. Please then complete part E of this form. | | |
| | Yes | Cannot decide | **No** |
| | | | |
| **E** | Action required and next steps | | |
| **E1** | If a full EHIA is planned:<br>Please state when the EHIA will be completed and by whom.<br>Name:<br>Date: | | |
| **E2** | If no decision is possible at this stage:<br>If it is not possible to state whether an EHIA will be completed, please summarise your reasons below and clearly state what additional information or work is required, when that work will be undertaken and when a decision about whether an EHIA will be completed will be made.<br><br>Summary reasons:<br><br>Additional information required:<br><br>When will it be possible to make a decision about an EHIA? | | |
| **E3** | If no EHIA is recommended:<br>If your recommendation or decision is that an EHIA is not required then please summarise the rationale for this decision below.<br>Summary reasons: This policy has been consulted on by the Quality & Patient Safety Tem.<br>There is no negative impact with respect to the characteristics as defined by the Equality Act. | | |

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| ***F*** | *Record Keeping* | | |
| **Lead originator:** | Sheila Dineley | Date: | 05.05.2017 |

[1] Yes: If the answers to the previous questions show the PSED or the duties to reduce health inequalities are engaged/in play a full EHIA will normally be produced. No: If the PSED and/or the duties to reduce health inequalities are not engaged/in play then you normally will not need to produce a full EHIA.

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| **Director signing off screening:** | Director or Nursing | Date: | 05.05.2017<br>14.07.2021 |
| **Directorate:** | Quality & Patient Safety | Date: | |
| **Screening published:** | This Version. | Date: | July 2021 |