Policy:

MD 010 Duty of Candour and Being Open

Executive Director Lead	Deputy Chief Executive, Executive Medical Director
Policy Owner	Patient Safety and Risk
Policy Author	Patient Safety and Risk

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Summary of policy
This policy is aimed at all healthcare staff responsible for ensuring the infrastructure is in place to support openness between healthcare professionals and service users and/or their carers following a complaint or an incident that led to moderate harm, severe harm or death.

Target audience	All staff, clinical and non-clinical, particularly anyone involved in Being Open/Duty of Candour meetings e.g. Consultants, Clinical and Service Directors, Assistant Clinical Directors and Assistant Service Directors, Matrons and Ward Managers/Lead Nurses, Serious Incident investigators, Chief Executive and Directors, SUMEU, Complaints and Litigation Department and Risk Management Department, Clinical Governance, Patient Safety and Information Governance.

Keywords	Duty of Candour; Being Open and Honest

Storage & Version Control
Version 5 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version (V4 April 2019). Any copies of the previous policy held separately should be destroyed and replaced with this version.

Version Control and Amendment Log (Example)

Version No.	Type of Change	Date	Description of change(s)
5	Review / approval / issue	12/2021	Interim review completed

Contents

Flowchart process information taken from section 7 of this policy document – flowchart to be followed and section 7 used to inform

1. Incident occurs – Incident report immediately

Refer to SHSC"s Incident Management Policy and Procedure for details of how an incident should be identified, reported and managed or the Complaints Policy for how complaints should be handled.

2. Incident Impact
Impact of 3 or above – Duty of Candour applies
(3. Moderate/4. Severe Harm/5. Death)

3. Agree how disclosure discussion will occur with patient/Next of Kin

- Urgent preliminary multi-team discussion as soon as possible (involve the risk team when required)

4. Initial disclosure and apology DO NOT DELAY –

1. As soon as possible – must be within 10 days of incident being known.

2. Disclosure and apology:
- By Consultant/MDT/Ward Manager/Senior Nurse
- Face to face/verbal or letter (using Duty of Candour template).
- Give disclosure, apology, information and support.
- Ensure information shared is accurate, do not speculate if it is unknown at this stage
- A sincere apology and explanation is what service users and their families want most and is vital to promote positive outcomes

3. Give outline of investigation process
- If it is a complaint **AND** SI – complaint is handled through SI investigation process.

4. Identify when/if patient would like to meet.

5. Identify senior person for further communication, if needed

6. Refer to investigation if severe harm/death – give Being Open leaflet

5. Record communication in Insight health records

- Clearly document 'Being Open – Duty of Candour'
- Record: Date, time, names present, issues, apology
- Plan for further communication

(update the risk team as needed)

6. Maintain contact, as agreed with patient/family

- Consider a second meeting, telephone call etc.
- On approval of investigation report –apology letter and summary sent to patient/family in conjunction with risk team processes.

1 Introduction

Candour and being open simply means being open and transparent when something has gone wrong.

It involves apologising and explaining what happened to service users and/or their carers who have been involved in a complaint or service user safety incident. A service user safety incident is defined as: Any unintended or unexpected incident that could have or did lead to harm for one or more service users receiving NHS funded healthcare' (NPSA 2005).

Communicating effectively with service users and/or their carers/Next of Kin is a vital part of the process of dealing with incidents, learning from these incidents and sharing our findings. In doing so, NHS organisations can mitigate the trauma or harm suffered by service users/family and potentially reduce lengthy formal complaints.

Research has shown that service users fully support the Duty of Candour and Being Open and will be more understanding of healthcare incidents when they are disclosed promptly, fully and compassionately.

Candour and openness have benefits for healthcare staff. These include satisfaction that communication with service users and/or their carers has been handled in the most appropriate way; developing a good professional reputation for handling a difficult situation properly; and improving their understanding of incidents from the perspective of the service user and/or their carers.

Candour and openness is also beneficial for the reputation of the Trust.

Setting the agenda for patient safety

Following the tragic events at Mid Staffordshire NHS Foundation Trust, the Patient Safety Domain has played a key role in taking forward the recommendations of the Francis Report, Berwick Report and Hard Truths, which set out the government's official response to the Francis Report. Service user safety and safe services are a key priority for Sheffield Health & Social Care, NHS Foundation Trust and there are a number of ongoing safety initiatives that focus on the reduction of harm and the increase in safety within the organisation. The Trust is committed to being an open and honest organisation that learns from safety incidents.

NHS England

NHS England is focused on safety and the continual reduction of avoidable harm, it supports organisations to become local learning systems with the ability to deliver high quality reliable healthcare. Systems centred on patients and devoted to learning have the freedom to evolve locally and become rooted in a culture relentlessly focused on safety at every level across the system.

National Health Service Resolution

The NHS Resolution is established to indemnify NHS Trusts in respect of both clinical negligence and non-clinical risks. It manages both claims and litigation and has established risk management programs against which NHS Trusts are assessed. The promotion of good risk management and governance are integral components of the NHS Resolution strategy

The NHS Resolution strategy envisages doing more, to save more money for patient care and to work with, and through others, to drive improvement.

What is staying the same?

- Core delivery – expert management of claims, concerns and disputes according to established principles of law.
- Saving money for patient care by the robust defence of claims where no compensation is due, including testing cases at trial and in the higher courts.
- Challenging over-charging by claimant lawyers, fighting fraud and excessive claims for compensation

What is different?

- Moving upstream to provide support closer to the incident with learning and local resolution.
- Reducing legal costs by keeping cases out of formal court proceedings and deploying alternative models for dispute resolution.
- Increased insight into what drives the costs of harm and developing interventions to respond to these, in partnership with others.

2 Scope

This policy is aimed at all healthcare staff responsible for ensuring the infrastructure is in place to support openness between healthcare professionals and service users and/or their carers following a complaint or an incident that led to moderate harm, severe harm or death.

It only relates to incidents or complaints that are classed as; Moderate harm (3), Major harm (4) or Catastrophic harm (5). It does not apply to Negligible (1) or Minor (2) incidents or complaints. However the principles of candour and being open apply to all the Trust"s dealings with those receiving services and members of the public.

Description	Impact on individual
1. Negligible	No Injury
2. Minor	Short term injury / no permanent damage/harm. Will be resolved in about 1 month.
3. Moderate	Semi-permanent injury/damage (emotional, physical or psychological) likely to resolve within one year.
4. Major	Permanent injury (Physical or psychological)
5. Catastrophic	Unexpected or untoward death

3 Purpose

This Trust is committed to the principles of the Duty of Candour and being Open Policy and this policy details the meaning of the Duty and Openness in practice.

4 Definitions

Complaint

A complaint is defined as an expression of dissatisfaction which requires a response whether it is verbally or in writing. Complaints may be about the activities of the Sheffield Health and Social Care NHS Foundation Trust and/or its staff.

Incident

An incident is any unplanned event which causes injury to people, damage or loss to property or contributes to both including those involving medication, e.g., prescribing, dispensing, administration or storage of medicines and missing patients.

A Serious Incident is an accident/incident when a patient, staff or visitor suffers serious injury, major permanent harm or unexpected death (or the risk of death or injury) on Trust premises where healthcare is provided or where actions of health service staff are likely to cause significant public concern.

Serious incidents include adverse or critical clinical incidents where events or circumstances arising during NHS care could have, or did, lead to unintended or unexpected harm, loss or damage. (Harm is defined as physical or psychological injury, disease, suffering, disability or death. Normally, harm is considered to be 'unexpected' if it is not related to the natural course of the patient's illness or underlying condition). (Serious Incident Framework 2015)

5 Duties

All staff working at SHSC should be aware of this policy and promote the principles and procedure of the Duty of Candour and Being Open when providing or supporting services. All senior managers and in particular those staff investigating incidents or complaints must read and follow this policy. Staff in the risk management and complaints management teams will provide support and advice in the application of the policy.

6 Responsibility for this policy

The Deputy Chief Executive and Medical Director have overall responsibility for this policy assisted by a non-Executive Director who also sits on the Trust Quality and Risk group. The joint operational leads for the implementation of the Policy are the Head of Integrated Governance and the Trust Clinical Risk Manager.

7 Specific Details

7.1 Process and requirements

The Duty of Candour and Being Open process begins with the recognition that a service user or staff member has suffered moderate or severe harm, or has died, as a result of a service user safety incident. A face-to-face apology should be given immediately. Clinical staff may worry that being open with patients may compromise the ability to deal with a claim if one is subsequently made by the patient. In reality candour is simply about sharing accurate information with service users and/or their family and should be encouraged.

The facts are the facts and staff will be encouraged and supported to help service users understand what has happened to them. Please refer to SHSC's Incident Management Policy and Procedure for details of how an incident should be identified, reported and managed (via Risk management and systems improvement techniques) or the Complaints Policy for how complaints should be handled. It is important that throughout the process, all communication relating to the incident or complaint is documented (details of the responsibilities relating to documentation can be found in the Trust's Incident Management Policy.

7.2 Preliminary Team Discussion

The multidisciplinary team, including the most senior health professional involved in the complaint or service user safety incident, should meet as soon as possible after the event to:

- Establish the basic clinical and other facts
- Assess the complaint /incident to determine the level of immediate response
- If the complaint or incident is rated as Moderate, Major or Catastrophic harm, the Duty of Candour and Being Open process will apply
- Offer a face to face apology immediately and document this in the health care record
- Identify who will be responsible for ongoing discussion with the service user and/or their carers

- Consider the appropriateness of engaging service user support at this early stage. This includes the use of a facilitator, a service user advocate or a healthcare professional who will be responsible for identifying the service users needs and communicating them back to the healthcare team; where criminal cases are involved, obtain specialist advice from the Police/Crown Prosecution Service (CPS);
    - However, where it is advised not to share information until a case is concluded, a letter/telephone contact should be considered by the appropriate Network lead to advise the service user or their carer that information will be shared and meetings facilitated as soon as possible following the Police investigation.
- Identify immediate support needs for the healthcare staff involved
- Ensure there is a consistent approach by all team members around discussions with the service user and/or their carers

Consider the timing of the Duty of Candour and Being Open discussion with the service user and/or carer. This meeting should happen as soon as possible after the complaint/ incident is recognised but availability of key stakeholders and the clinical condition of the service user should be considered.

7.3 Choosing the individual best placed to communicate with the service users and/or carers, and who to communicate with

The healthcare professional who informs the service user and/or their carers about a service user safety incident should be the most senior person responsible for the service users care and/or someone with experience and expertise in the type of incident that has occurred. This could either be the service users consultant, nurse consultant, or any other senior healthcare professional that has a designated caseload of service users. They should have received training in the communication of service user safety incidents.

Consideration also needs to be given to the characteristics of the healthcare professional nominated to lead the Duty of Candour / Being Open process. They should:

- Be known to, and trusted by, the service user and/or their carers
- Have a good grasp of the facts relevant to the complaint/incident
- Be senior enough or have sufficient experience and expertise in relation to the type of service user safety incident to be credible to service users, carers and colleagues
- Be able to commit to the time needed to complete the Duty of Candour and Being Open process
- Have excellent interpersonal skills, including being able to communicate with service users and/or their carers in a way they can understand and avoiding any use of medical jargon
- Be willing and able to offer an immediate face to face apology, reassurance and feedback to service users and/or their carers
- Be able to maintain a medium to long term relationship with the service user and/or their carers, where possible, and to provide continued support and information
- Be culturally aware and informed about the specific needs of the service user and/ or their carers
- Be mindful that service users and carers may require additional support i.e. professional services, support groups etc and how to access these

Junior staff (or those in training) should not lead the Duty of Candour / Being Open process, but may attend as an observer for training purposes with the explicit and informed consent of the service user and/or carer.

There should always be communication with the service user unless there are strong clinical reasons not to do so, for example if the service user is too unwell at the time. In the event of the death of a service user, the closest family member or carer should normally be

communicated with. The clinical team will need to decide who this should be from their knowledge of the service use's family circumstances.

It is essential practice to include communication with close family members or carers as well as the service user affected by a serious incident or complaint. However, the views of the service user about confidentiality and whether to involve family members should be considered in deciding who to contact.

The decision about who to contact must be recorded. If it is decided not to contact either the service user or carer, the reason for not contacting them must be recorded. This will form part of the incident or complaint investigation record.

Supporting healthcare staff who have been involved in the incident

Some service user safety incidents that resulted in moderate harm, severe harm or death will result from errors, due to system failures, made by healthcare staff while caring for the service user. In these circumstances the member(s) of staff involved may or may not wish to participate in the Duty of Candour / Being Open discussion with the service user and/or their carers. Every case where an error has occurred needs to be considered individually, balancing the needs of the service user and/or their carers with those of the healthcare professional concerned. In cases where the healthcare professional who has made an error wishes to attend the discussion to apologise personally, they should feel supported by their colleagues throughout the meeting. In cases where the service user and / or their carers express a preference for the healthcare professional not to be present and if the health care worker is willing, a personal written apology can be handed to the service user and/or their carers during the first Duty of Candour / Being open discussion if appropriate.

7.4 Preparation for the preliminary meeting with the service user and/or their carer

Who should attend?

- The senior SHSC staff member who has been chosen to lead the Duty of Candour / Being open process
- The person taking the lead should be supported by at least one other member of staff, such as the clinical risk manager, complaints manager, nursing or medical director or member of the healthcare team treating the service user.
- Ask the service user and/or their carers who they would like to be present
- Hold a pre-meeting amongst healthcare professionals so that everyone knows the facts and understands the aims of the meeting

When should it be held?

- Within 10 days of the complaint/incident being known
- Consider the service users and/or their carers home and social circumstances
- Check they are happy with the timing
- Offer them a choice of date/times and confirm the chosen date/time in writing
- Do not cancel the meeting unless it is absolutely necessary Where should it be held?
- Use a quiet room where you will not be distracted by work or interrupted
- Do not host the meeting near to the place where the incident occurred if this is difficult for the service user and/or their carers
- Offer to meet at the service users home if this is most suitable for them What should be prepared in advance of the meeting?
- Investigate possible sources of support and counselling that you anticipate the service user and /or carer may need as a result of the incident or complaint.
- Investigate the needs of service users with special circumstances, for example, linguistic or cultural needs, and those with learning disabilities or cognitive impairment. SHSC has access to spoken language interpreters, British Sigh Language interpreters for hearing impaired service users, and Deaf-Blind Communication Support Workers.

The SHSC Service User Engagement team (SUMEU) should be able to help you organise this

How should you approach the service user and/or their carers?

- Speak to the service user and/or their carers as you would want someone in the same situation to communicate with you or your own family
- Do not use jargon or acronyms: use clear, straightforward language
- Consider the needs of service users with special circumstances, for example linguistic or cultural needs, people with cognitive impairment, learning disabilities and people with sensory needs

7.5 Content of the preliminary meeting discussion

What should be discussed?

- The service user and/or their carers should be advised of the identity and role of all people attending the Duty of Candour / Being Open discussion before it takes place. This allows them the opportunity to state their own preferences about which healthcare staff should be present.
- All incidents should be acknowledged within 10 days of the incident being known.
- There should be an expression of genuine sympathy, regret and an immediate apology for the harm that has occurred.
- All communication should be truthful, timely, clear and confidential.
- The facts that are known are agreed by the multidisciplinary team. Where there is disagreement, communication about these events should be deferred until after the investigation has been completed. The service user and/or their carers should be informed that an investigation is being carried out and more information will become available as it progresses.
- It should be made clear to the service user and/or their carers that new facts may emerge as the complaints/incident investigation proceeds.
- The service users and / or carers understanding of what happened should be taken into consideration, as well as any questions they may have.
- There should be consideration and formal noting of the service users and/or carers views and concerns, and demonstration that these are being heard and taken seriously.
- Appropriate language and terminology should be used when speaking to service users and/or their carers. For example, using the terms ‘service user safety incident’ or ‘adverse event’ may be at best meaningless and at worst insulting to a service user and/or their carers. If a service users and/or their carers first language is not English, it is also important to consider their language needs – if they would like the Duty of Candour / Being open discussion conducted another language this should be arranged.
- An explanation should be given about what will happen next in terms of the long term treatment plan and incident findings.
- Information on likely short and long term effects of the incident (if known) should be shared. The latter may have to be delayed to a subsequent meeting when the situation becomes clearer.
- An offer of practical and emotional support should be made to the service user and/or their carers. This may involve getting additional help from third party professional support, such as charities and voluntary organisations as well as offering more direct assistance. Information about the service user and the incident should not normally be disclosed to third parties without consent.
- It should be recognised that service users and/or their carers may be anxious, angry and frustrated even when the Duty of Candour / Being Open discussion is conducted appropriately.

- Contact details for the healthcare professional leading the Duty of Candour / Being Open process should be given to the service user and/ or carer.

It is essential that the following does not occur:

- Speculation
- Attribution of blame
- Denial of responsibility
- Provision of conflicting information from different individuals.

The initial Duty of Candour / Being Open discussion is the first part of an ongoing communication process. Many of the points raised here should be expanded on in subsequent meetings with the service user and/or their carers.

What should be documented?

The following should be documented and passed to the Clinical Risk Manager or Complaints Manager (as appropriate) once the Duty of Candour / Being Open meeting is complete:

- The time, place, date, as well as the name and relationships of all attendees
- The plan for providing further information to the service user and/or their relative / carers
- Offers of assistance and the service users and/or their relative / carers response
- Questions raised by the family and / or carers or their representatives, and the answers given
- Plans for follow-up as discussed
- Progress notes relating to the clinical situation and an accurate summary of all the points explained to the service user and/or their relative / carers
- Copies of letters sent to the GP for service user safety incidents not occurring within primary care
- Copies of any statements taken in relation to the service user safety incident or complaint
- A copy of the incident report or complaint letter. Full minutes of the Duty of Candour / Being Open discussion meeting, which should be signed and dated by the Chair and all members of the panel present, should be shared with the service user and/or their relative / carer

Clarify in writing the information given; reiterate key points, record action points and assign responsibilities and deadlines.

7.6 Follow up meetings with service users and/or carers

The Duty of Candour and Being Open is not a one-off event and regular follow up meetings should be arranged by the investigation lead to ensure that staff, the service user or service user and/or relative / carers are kept updated:

- Clarify in writing the information given, reiterate key points, record action points and assign responsibilities and deadlines
- The service users notes should contain a complete, accurate record of the discussion(s) including the date and time of each entry, what the service user and / or their carers have been told and a summary of agreed action points
- Maintain a dialogue by addressing any new concerns, share new information once available and provide information on counselling, as appropriate
- Try to include the service user and carer in generating solutions to any problems identified through the investigation.
- Consideration should be given to the timing of meeting, based on both the service users health and personal circumstances.

- Consideration should be given to the location of the meeting e.g. the service users home.
- Feedback should be given on progress to date and information provided on the investigation process.
- There should be no speculation or attribution of blame. Similarly, the healthcare professional communicating the incident must not criticise or comment on matters outside their own experience.
- The service user and/or their carers should be offered an opportunity to discuss the situation with another relevant professional where appropriate.
- Service users are entitled to expect that they will continue to receive all usual treatment and continue to be treated with dignity, respect and compassion. If a service user expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made for them to receive treatment elsewhere.
- A written record of the discussion should be kept and shared with the service user and/or their carers (see 7.5 for details of documentation recommended).
- All queries should be responded to appropriately.
- If completing the process at this point, the service user and / or their carers should be asked if they are satisfied with the investigation and a note of this made in the service users records.
- The service user should be provided with contact details so that if further issues arise later there is a conduit back to the relevant healthcare professionals or an agreed substitute.
- If completing the process the service user and/or their family should have received a written document outlining the findings of the investigation and this should include a written apology for the harm caused.

7.7 Completing the Process

Communication with the service user and/or their carers

After completion of the complaint/incident investigation, feedback should take the form most acceptable to the service user. Whatever method is used, the communication should include:

- The chronology of clinical and other relevant facts
- Details of the service users and/or their carers concerns and complaints
- A repeated written apology for the harm suffered and any shortcomings in the delivery of care that led to the service user safety incident
- A summary of the factors that contributed to the incident
- Information on what has been learned and what will be done to avoid recurrence of the incident and how these improvements will be monitored

It is expected that in most cases there will be a complete discussion of the findings of the investigation and analysis. In some cases information may be withheld or restricted, for example, where communicating information will adversely affect the health of the service user; where investigations are pending coronial processes; or where specific legal requirements preclude disclosure for specific purposes. In these cases the service user will be informed of the reasons for the restrictions.

Continuity of care

When a service user has been harmed during the course of treatment and requires further therapeutic management or rehabilitation, they should be informed, in an accessible way, of the ongoing clinical management plan. This may be encompassed in discharge planning processes addressed to designated individuals such as the referring GP when the service user safety incident has not occurred in primary care. Service users and / or their carers should be reassured that they will continue to be treated according to their clinical needs

even in circumstances where there is a dispute between them and the healthcare team. They should also be informed that they have the right to continue their treatment elsewhere if they have lost confidence in the healthcare team involved in the service user safety incident

Communication with the GP and other community care service providers for service user safety incidents not occurring in primary care
Wherever possible, it is advisable to send a brief communication to the service users GP, before discharge, describing what happened.

When the service user leaves the care of the Trust, a discharge letter should also be forwarded to the GP or appropriate community care service. It should contain summary details of:

- The nature of the service user safety incident and the continuing care and treatment
- The current condition of the service user
- Key investigations that have been carried out to establish the service users clinical condition
- Recent results
- Prognosis.

It may be valuable to consider including the GP in one of the follow-up discussions either at discharge or at a later stage.

Monitoring and compliance
Any recommendations for systems improvements and changes implemented should be monitored for effectiveness in preventing a recurrence. The investigation report will include recommendations and an action plan together with lead roles for implementing any changes agreed and timescales. Progress on the action plan will be followed up by the senior leadership team of the Network concerned and the Trusts Service User Safety Group. Continuing feedback on progress on action plans to the service user and / or carer should be agreed as part of the action plan, in response to what the service user and/or carer wants to know.

Communication of changes to staff
Effective communication with staff is a vital step in ensuring that recommended changes are fully implemented and monitored. It will also facilitate the move towards increased awareness of service user safety issues and the value of the Duty of Candour and being open.

8 Development, Consultation and Approval

This section should include details of:

- *Who was involved in developing the policy and any guidance followed?*
- *Groups and individuals consulted (including staff side groups and service user carer involvement including link back to the Equality Impact Assessment).*
- *Any changes made as a result of the consultation including key changes e.g. legislative changes*
- *Which governance group reviewed the document*
- *Dates for consultation and review.*

9 Audit, Monitoring and Review

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) How incidents are reported and reviewed in line with Duty of Candour	Review of incident reports, reported Duty of Candour events and review of incident investigations reports	Risk Management Department	6 Monthly	Service User Safety Group	Service User Safety Group	Service User Safety Group
B) How staff acknowledge apologise and explain when things go wrong	Review of incident reports, reported Duty of Candour events and review of incident investigations reports	Risk Management Department	6 Monthly	Service User Safety Group	Service User Safety Group	Service User Safety Group
C) Requirements for truthfulness, timelines and clarity of communication	Review of incident reports, reported Duty of Candour events and review of incident investigations reports	Risk Management Department	6 Monthly	Service User Safety Group	Service User Safety Group	Service User Safety Group

D) How additional support is provided	Review of incident reports, reported Duty of Candour events and review of incident investigations reports	Risk Management Department	6 Monthly	Service User Safety Group	Service User Safety Group	Service User Safety Group
E) How communication is recorded	Review of incident reports, reported Duty of Candour events and review of incident investigations reports	Risk Management Department	6 Monthly	Service User Safety Group	Service User Safety Group	Service User Safety Group

This policy will be reviewed in 3 years time. Further audit, monitoring and review will be agreed at that point.

10 Implementation Plan

Action / Task	Responsible Person	Deadline	Progress update
Dissemination, storage and archiving Post on Trust intranet	Post on Trust intranet		
	'All SHSC staff' email alert		
	OMG email alert to directors		
	Team managers to ensure all staff have access to latest version of this policy, and the previous		

	guidance is removed and destroyed		
Training and development	Amend induction programme for all staff and for new managers		
	Amend induction programme for all staff and for new managers		
New roles and responsibilities	Clinical audit programme to include audit of implementation of this policy		

11 Dissemination, Storage and Archiving (Control)

This policy will be posted on the Sheffield Health and Social Care NHS Foundation Trust intranet website and available to all staff within 7 days of its ratification. There will be a link to the policy on the homepage of the intranet website.

A communication to staff informing them of this new policy will be sent via the appropriate communication systems. In addition Clinical, Service and Support Directors will be instructed to ensure that all teams and areas are made aware of this policy and how to apply it.

A web link or copy will be sent to any members of staff that investigate an incident or a complaint by the risk management or complaints team.

The Integrated Governance team will keep a paper and an electronic version of the previous guidance for archive purposes. Please contact them if a copy is needed.

Version	**Date added to intranet**	**Date added to internet**	**Date of inclusion in Connect**	**Any other promotion/ dissemination (include dates)**
5	January 2022	January 2022	January 2022	

12 Training and Other Resource Implications

All staff should be made aware of the Duty of Candour and Being Open policy. This will be done through the Trust's usual communication systems when a policy has been developed / reviewed. New staff will be made aware of the policy through induction processes.

Staff who are responsible for incident, complaint and claims management can receive advice and support on this policy through the Trust's Head of Integrated Governance, Clinical Risk Manager and the Complaints and Litigation Lead.

Training in this policy has been developed to be delivered through the induction process and in line with continuing professional development for existing staff in the form of refresher training sessions.

13 Links to Other Policies, Standards (Associated Documents)

This policy should be read in conjunction with SHSC Complaints Procedure and Claims Policy and SHSC Incident Management Policy.

14 Contact Details

Title	***Name***	***Phone***	***Email***
Patient Safety Investigator	Darren McCarthy		Darren.McCarthy@shsc.nhs.uk

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date:	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	**This policy has no impact with relation to age**		
Disability	**Yes**		**Different format or explanation of content would need to be provided and further explanations and support to understand the policy.**
Gender Reassignment	**This policy has no impact with relation to gender reassignment**		
Pregnancy and Maternity	**This policy has no impact with relation to pregnancy or maternity**		

Race	**Yes**		**Different format or explanation of content would need to be provided and further explanations and support to understand the policy.**
Religion or Belief	**This policy has no impact with relation to religion or belief**		
Sex	**This policy has no impact with relation to sex**		
Sexual Orientation	**This policy has no impact with relation to sexual orientation**		
Marriage or Civil Partnership	**This policy has no impact with relation to marriage or civil partnership**		

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Impact Assessment Completed by:
Name /Date Darren McCarthy December 2021

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	✓
2.	Is the local Policy Champion member sighted on the development/review of the policy?	✓
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N/A
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	✓
5.	Has the policy been discussed and agreed by the local governance groups?	✓
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	✓
	Template Compliance	
7.	Has the version control/storage section been updated?	✓
8.	Is the policy title clear and unambiguous?	✓
9.	Is the policy in Arial font 12?	✓
10.	Have page numbers been inserted?	✓
11.	Has the policy been quality checked for spelling errors, links, accuracy?	✓
	Policy Content	
12.	Is the purpose of the policy clear?	✓
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	
15.	Where appropriate, does the policy contain a list of definitions of terms used?	N/A
16.	Does the policy include any references to other associated policies and key documents?	✓
17.	Has the EIA Form been completed (Appendix 1)?	✓
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	✓
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	✓
20.	Is there a plan to i. review ii. audit compliance with the document?	✓
21.	Is the review date identified, and is it appropriate and justifiable?	✓