Royal Cornwall Hospitals
NHS Trust

Being Open and Duty of Candour Policy

V5.0

March 2025

Every healthcare professional must be open and honest with patients. Every NHS Trust, since November 2014, has a statutory Duty of Candour.

Candour is defined by Robert Francis as: 'The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made'.

The Being Open principles and ethical duty of openness apply to all incidents and any failure in care or treatment. The Duty of Candour applies to incidents whereby moderate harm, significant harm, prolonged psychological harm, or death has occurred.

It is a matter of judgment that needs to be exercised on a case by case basis to determine whether an incident that meets the Duty of Candour criteria has occurred. What may not appear to be such an incident at the outset may look very different once more information comes to light and may therefore lead to an incident becoming notifiable under the Duty of Candour.

The requirements of the Duty of Candour are as follows:

As soon as reasonably practicable after becoming aware that a safety incident has occurred that falls into the moderate harm or more serious categories the healthcare professional must:

(a) Notify the 'relevant person' (this is usually the patient but may in some circumstances be the relative, carer or advocate) that the incident has occurred and,

(b) Provide reasonable support to the relevant person in relation to the incident.

The notification must:

(a) Be given in person by one or more members of staff.

(b) Provide an account of all the facts known about the incident to date.

(c) Advise the relevant person what further enquiries into the incident will be undertaken.

(d) Include an apology and/or a sincere expression of regret, and.

(e) Be recorded electronically and/or in patient notes where applicable.

This notification must be followed up in writing to the relevant person. The member of staff should be clear in the first meeting that the facts may not yet have been established, tell the relevant person only what is known and believe to be true, and answer any questions honestly and as fully as they can.

The organisation then has a responsibility to share the investigation findings with the relevant person once these are clear. The aim of the Duty is to ensure that patients are told when harm occurs as a result of the care they receive. Where the degree of harm is not yet clear but may fall into the moderate or above categories, then the relevant person must also be notified.

Duty of Candour (DoC) and Being Open Processes

(Note – where this flow chart states ‘patient’ this means patient, family, or carer, whomever is the point of contact).

As soon as possible after an incident has been identified, assess harm, and give any required clinical care to prevent further harm.

Report incident on Datix and to the person in charge.

Consider Whether a being open conversation is needed.

No

Level of Harm Moderate, Severe or Death.

Yes

Provide support to patient and any staff affected by the incident. Begin the DoC process, the 10 working days to complete Doc starts now.

Decide on the most appropriate person to lead on Duty of Candour – this would usually be the Lead Clinician in charge of the patient’s care and treatment or another senior member of staff familiar with the patient or incident details.

Provide apology verbally, providing all known facts and identify next steps for keeping patient informed. Document discussion in patient records or electronic records and on the relevant incident on Datix. Follow up with written letter of apology within 10 working days of the incident, including details of all information provided in previous conversation and contact details.

Investigating Officer (IO) appointed for PSR 2 / PSII

Talk to patient, apologise again and provide details of the process. Ask how the patient would like to be involved and outline the further enquiries to be made. Provide contact details and give date of investigation conclusion. Notify patient that once complete you will be in touch again to go through the findings.

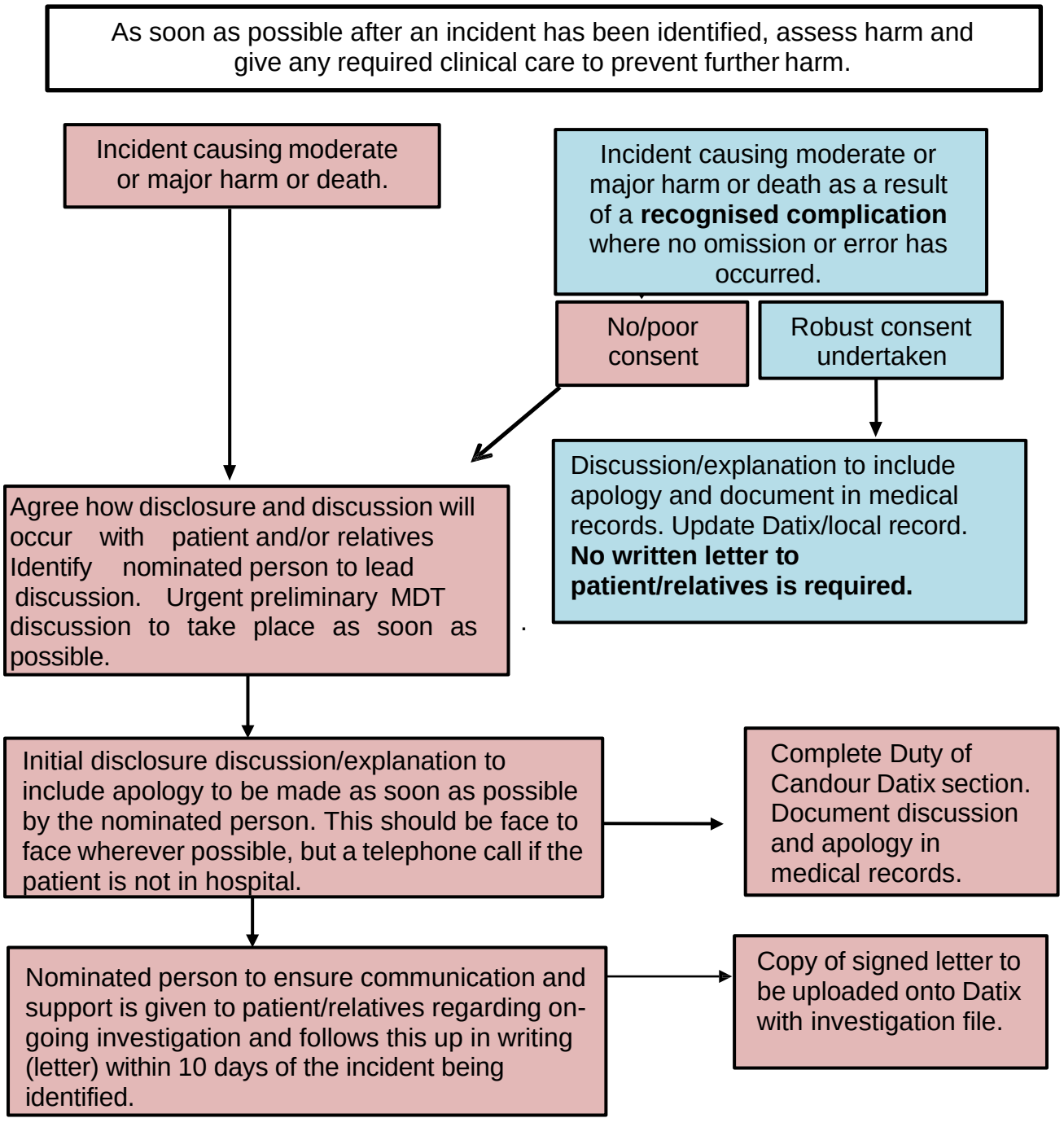
Provide update on known facts at regular intervals and respond to queries.

If agreed, share findings of the investigation with the patient together with the lessons learned and actions taken or to be taken. Discuss any necessary continuation of care. Send a covering letter with further apology and opportunity to ask further questions.

Ensure all communication and written correspondence is appropriately recorded in patient records and Datix.

Duty of Candour (DoC) with regard to recognised complications

(Note – where this flow chart states 'patient' this means patient, family, or carer, whomever is the point of contact).



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Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

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1. Introduction

1.1. Being open encourages a culture of safety that supports organisational and personal learning. Transparency and openness with patients, their carers and/or family promotes open discussion of concerns and prompts action for the mitigation or prevention of recurrence of incidents. It involves apologising and explaining what happened to patients and/or their family or carers following a patient safety incident.

1.2. Staff also have a duty to be open and honest with the organisation by reporting patient safety incidents that lead to harm as well as near misses. The Trust's processes for this and commitment to a 'just culture' can be found in the Trust policies concerning incident reporting, management, and investigation.

1.3. Being open following a patient safety incident is integral to the Duty of Candour. Healthcare professionals already have a professional Duty of Candour as laid out in their codes of practice such as the Good Medical Practice (General Medical Council; GMC), The Code: Professional standards of practice and behaviour for nurses and midwifery (Nursing and Midwifery Council; NMC) and The Standards of Performance and Ethics from the Healthcare Professions Council. These all concur that healthcare professionals have a professional Duty of Candour to be open and honest with patients when things go wrong during treatment that has caused or has the potential to cause harm or distress.

1.4. In response to the Francis Inquiry the Care Quality Commission (CQC) introduced **Regulation 20: Duty of Candour**, which came into force on the 27 November 2014. This regulation lays out a 'statutory Duty of Candour'. This organisational duty requires health providers to act in an open and transparent way. It includes all aspects of the professional Duty of Candour and, in addition, the actions which providers must undertake when the threshold of a 'notifiable safety incident' is reached (see section 4.1 for full definition). These are:

- Carry out a thorough investigation into the causes of the incident and share relevant details and findings with the patient and/or relevant other.
- Provide an apology in writing, following the verbal apology in person within 10 working days of the incident being reported.
- Provide reasonable support to the patient in relation to the incident.
- Establish a formal and defined process of harm disclosure as part of the provider's governance processes.

1.5. The statutory duty is a legal requirement on health providers. However, individual clinicians are relied on to discharge it on behalf of the organisation. Regulation 20 makes clear that cooperation between a healthcare organisation and its staff is vital. The Trust will support staff in being open and honest with patients.

1.6. The Trust also has a duty to be open and honest with regard complainants. The CQC's Regulation 16: Receiving and acting on complaints states that 'providers must act in accordance with Regulation 20: Duty of Candour in respect of complaints about care and treatment that have resulted in a notifiable safety incident'. The NHS Constitution (2013) commits the NHS to treat all complainants with courtesy, giving an apology and ensuring that appropriate explanation is given.

1.7. Non-compliance with 'statutory duty of candour' (Regulation 20: Duty of Candour: The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)) is a criminal offence and the CQC can move directly to prosecution without serving a Warning Notice. The CQC may take other regulatory action where non-compliance is evidenced. Further information on the Statutory Duty of Candour can be found here: Regulation 20: Duty of candour - Care Quality Commission (cqc.org.uk)

1.8. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

This policy applies to all staff including permanent and temporary staff employed by the Trust. The policy also applies to students, bank and locum staff, contracted staff, and volunteers. Every healthcare professional in the Trust must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress.

3. Scope

3.1. The Being Open principles (Appendix 4) and ethical duty of openness applies to all incidents and any failure in care or treatment. The Duty of Candour applies to incidents whereby moderate harm, significant harm or death has occurred. See Figure 1 below.

Figure 1: Applicability of Being Open/Duty of Candour

Harm assessment	Impact on patient	Communication process
No / low / minor harm	No impact	Being Open
Moderate harm	At least one of the criteria identified in section 4.6 is met	Duty of Candour
Severe harm	At least one of the criteria identified in section 4.7 is met	Duty of Candour
Catastrophic harm/ death	Death	Duty of Candour

3.2. There will be exceptions to implementing the Duty of Candour, such as when it may cause unacceptable additional distress/mental health issues to the individual (see Appendix 3 for more detail). These must be very sound reasons, which must be clearly recorded on the Datix record, for not having the Duty of Candour principles applied.

3.3. This policy deals with the information and methods of sharing of information with the relevant person. Patients and those close to them will vary in how much information they want, and when they want it. Some people will want as much detail as possible, including details of rare risks, to those who ask health professionals to make decisions for them. There will always be an element of professional judgement in determining what information should be given.

3.4. However, the presumption must be that the relevant person wishes to be well informed about the risks and benefits of the various options. Where the relevant person makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.

3.5. It should be noted that the statutory duty of candour does not refer to / is not triggered by recognised complications of a procedure where no omission or error has occurred, following a robust consenting process.

3.6. **Implications of not implementing the Duty of Candour requirements**

The CQC in their guidance relating to the Duty of Candour explain the approach they will be taking to assess whether a provider is complying with the new regulation.

3.6.1. As the Duty of Candour is a statutory requirement, non-compliance is a criminal offence.

3.6.2. Commissioners can withhold the cost of the episode of care or implement a fine of £10,000 if the cost is not known. In addition, they can do any/all of the following:

3.6.3. Inform the CQC, they require that the Chief Executive send an apology and an explanation of the breach to the patient/relatives and publish details of the breach on the Trust website.

3.6.4. The CQC's key lines of enquiry will be:

- Are lessons learned and improvements made when things go wrong?
- Are people who use services told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result?
- How does the leadership and culture reflect the vision and values, encourage openness and transparency, and promote good quality care?
- Does the culture encourage candour, openness, and honesty?

3.7. **Incidents that are later uncovered or that have occurred within the care of another provider**

On occasion, an incident that happened some time ago may be discovered. The incident should be reported in the usual way on Datix, and agreement reached by the senior clinician and the Director of Nursing, Midwifery and Allied Health Care Professionals to the most appropriate action to take. A delay in discovering an incident does not mean the Duty of Candour does not apply. The processes however may require additional consideration in order that the patient is informed of the incident with care to avoid unexpected shock or distress.

Incidents that are discovered that relate to care delivered by another provider will be reported to a senior manager in that organisation, and to the commissioning body. That organisation is then responsible for implementing the Duty of Candour. The Trust will work in partnership with other providers to ensure the Duty of Candour applies as an economy wide, patient-centered policy.

4. Definitions / Glossary

4.1. **Patient Safety Incident** - Any incident affecting patients or service users, irrespective of the consequences, impact, or harm caused. This is a clinical incident affecting the care or outcome for the patient.

4.2. **Notifiable Safety Incident** – any unintended or unexpected incident that occurred in respect of a patient's care that, in the reasonable opinion of a healthcare professional, could result in, or appears to have resulted in:

- The patient's death.
- Severe harm.
- Moderate harm.
- Prolonged psychological harm.

4.3. This definition (and the whole duty of candour) refers to harm directly caused by the incident, and not by the natural course of the patient's illness or underlying condition.

4.4. Identifying something as a notifiable safety incident does not automatically imply error, negligence, or poor-quality care. It simply indicates that an unexpected and undesirable clinical outcome resulted from some aspect of the patient's care, rather than their underlying condition.

4.5. **Low physical harm is when all of the following apply:**

- Minimal harm occurred – patient(s) required extra observation or minor treatment.
- Did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit.
- Did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication.
- Did not or is unlikely to affect that patient's independence.
- Did not or is unlikely to affect the success of treatment for existing health conditions.

4.6. **Moderate physical harm** - is when at least one of the following apply:

- Has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment and did not need immediate life-saving intervention.
- Has limited or is likely to limit the patient's independence, but for less than 6 months.
- Has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm.

4.7. **Severe physical** - is when at least one of the following apply:

- Permanent harm/permanent alteration of the physiology.
- Needed immediate life-saving clinical intervention.
- Is likely to have reduced the patient's life expectancy.
- Needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment.
- Has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions.
- Has limited or is likely to limit the patient's independence for 6 months or more.

4.8. **Apology** – an expression of sorrow or regret in relation to an unexpected incident that resulted in patient harm. Apology does not imply acceptance of responsibility for the incident and the resulting harm. In some cases, however, where harm is linked to an error in the care of the patient, then an apology should also include an acknowledgement and acceptance of responsibility.

4.9. **Prolonged pain** - pain which a patient has experienced, or is likely to experience, for a continuous period of at least 28 days.

4.10. **Written notification** – one given or sent to the relevant person in written form containing the information provided in any initial notification made in person, details of any enquiries to be undertaken, advise of any appropriate enquiries to be undertaken, the results of any further enquiries, and an apology.

4.11. **Compliance** – to be fully compliant with Duty of Candour, a letter should be sent to the patient/NOK or nominated person within 10 working days of the incident being identified, following verbal Duty of Candour.

4.12. **Working Days** - means any day which is not a Saturday, Sunday, or public holiday.

4.13. **Openness** – Being open involves apologising when something has gone wrong, being open and honest about what has happened, how and why it may have happened, and keeping the patient and their family informed as part of any subsequent review.

4.14. **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

4.15. **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

4.16. **Psychological harm** – An assessment is now asked for when reporting incidents so that psychological harm is recorded, as well as physical harm. Psychological harm is described as follows:

4.16.1. **Low psychological harm -** when **at least one** of the following apply:

- Distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit.
- Distress that did not or is unlikely to affect the patient's normal activities for more than a few days.
- Distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition.

4.16.2. **Moderate psychological harm** - when **at least one** of the following apply:

- Distress that did or is likely to need a course of treatment that extends for less than six months.

- Distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months.

- Distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months.

4.16.3. **Severe psychological harm** - when **at least one** of the following apply:

- Distress that did or is likely to need a course of treatment that continues for more than six months.

- Distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months.

- Distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months.

5. Ownership and Responsibilities

All staff have a responsibility to promote a culture of openness and honesty at all levels within the organisation.

5.1. Role of the Trust Board

The Chief Executive, Medical Director, Dual Chief Nursing Officer, Director of Nursing, Midwifery and Allied Health Care Professionals and Executive Directors must ensure that mechanisms are in place to enable all staff to adhere to this policy. This includes a Trust wide mandatory training to ensure that responsible staff have the skills to 'Say Sorry' confidently and, when required, to conduct an investigation of the patient safety causes and contributory factors which are shared with the person (or relevant other) in an open and transparent manner.

5.2. Role of the Director of Nursing, Midwifery and Allied Health Care Professionals

The Director of Nursing, Midwifery and Allied Health Care Professionals holds overall responsibility for this policy. This includes:

- The development, implementation, and review of this policy.

- Ensuring the processes are in place so that meaningful information about reporting and management is presented to and reviewed by the Trust Board.

- Joint responsibility or delegated responsibility to a nominated deputy for defining and verifying an incident as requiring Duty of Candour.

- Ensuring that the Dual Chief Nursing Officer and Chief Executive (CEO) is kept fully informed about compliance with Duty of Candour and for reporting compliance to the Quality Assurance Committee.

- Ensuring reporting is carried out in line with the Care Quality Commission (CQC) regulatory framework.

- Provide professional leadership and independent clinical overview for the Trust Board, regarding Duty of Candour.

5.3. Role of Care Group Management Teams

The role of the Care Group Management Team (Clinical Director, Head of Nursing/Midwifery and General Manager, Head of Business and Quality Assurance) is to ensure that all staff are aware of and adhere to this policy. This includes ensuring that there are mechanisms in place within the Care Group for the identification of incidents that trigger the statutory Duty of Candour, monitoring compliance with this policy and addressing non- compliance via the appropriate management route.

5.4. Role of Care Group Governance Leads

Care Group Governance Leads are also responsible for:

- Monitoring compliance with required timescales and escalating concerns of non-compliance and non-completion with regards to Duty of Candour.

- Ensuring that the Duty of Candour fields are completed on the electronic incident report form (Datix incident report) with evidence uploaded.

- Ensuring where there have been any delays in completing the DoC process within the 10 working days from when the incident was identified, that those reasons are clearly documented in the DoC Progress Notes on the Datix incident report to allow themes and learning to be identified, this information will be reported in the Incident Review and Learning Group monthly report for discussion at QAC.

- Attend the Incident Review and Learning Group to update on all open records where Duty of Candour has not yet been completed.

- Undertaking a quarterly spot-check of 10 cases auditing the quality of Duty of Candour correspondence and compliance with its requirements and share these findings at the care group governance huddles to drive improvement and learning.

5.5. Role of Medical Consultants and Matrons

Medical Consultants and Matrons have a number of responsibilities, as follows:

- Ensuring the Duty of Candour is implemented in the way it is intended.

- Deciding who will provide the initial notification to the patient or relevant other. In many circumstances this will be the senior clinician responsible for the patient's care.

- Ensuring an appropriate person is identified to be the contact person with the person affected or relevant other during the process.

- Ensuring that all conversations with the relevant people are recorded either in the medical notes or through the written DoC letter where notes are not available and uploaded to both Datix and Maxims.

- Ensuring that staff and patients involved in incidents are provided with the support they require.

5.6. Role of a Patient Safety Investigation Officer (IO)

5.6.1. Where incidents are confirmed as requiring a Patient Safety Review 2 (PSR2) or a Patient Safety Incident Investigation (PSII), an Investigating Officer (IO) will be appointed. They will communicate with the person affected or relevant person, introducing themselves as the IO and explaining the process for further investigation. This communication should be verbal (face to face, virtual or by telephone) and then followed up with a letter within 10 working days of the incident being identified.

5.6.2. On nomination the IO will receive a Resource Pack outlining responsibilities in relation to Duty of Candour, including templates to assist communications with patients and their families.

5.7. Role of ward/department and managers

Ward and department managers should ensure that their staff:

- Know how and why to report incidents, including grading the level of harm.

- Recognise an incident that triggers the statutory Duty of Candour.

- Know how to escalate such an incident so that the Duty of Candour process is completed within the required 10 working days from the recognition of the incident.

- Ensure that any of their staff involved in an incident are offered appropriate support.

5.8. Role of all staff

All staff involved in being open and duty of candour processes should adhere to this policy and ensure it is implemented.

5.9. Role of the Associate Director for Quality Governance:

The Associate Director for Quality Governance will ensure policies and processes are in place to enable the Trust and its staff to enact the requirements of CQC Regulation 20: Duty of Candour.

This will include:

- As Chair of the Incident Review and Learning Group, the Director of Nursing, Midwifery and Allied Health Care Professionals is responsible for ensuring compliance with Duty of Candour.

- To ensure processes are in place for the central monitoring and reporting on the level of compliance with the Duty of Candour process following notifiable safety incidents.

- To ensure that effective risk-management processes are in place to support the Being Open/Duty of Candour Policy management of notifiable patient safety incidents, including the provision of expert advice, resources, training, and education.

5.10. Role of the Quality Assurance Committee (QAC)

QAC has responsibility for monthly monitoring of compliance with Duty of Candour.

5.11. Role of the Incident Review and Learning Group (IRLG)

The group is chaired by the Associate Director for Quality Governance and is attended by various members of staff internally and externally regarding quality and safety. The primary purpose of IRLG is to provide clinical expertise and executive oversight of all reported PSR2s, PSIIs and/or Never Event investigations. The group reviews all relevant reports to ensure the quality of the investigation is of a high standard, and that associated action plans are comprehensive and robust. The group monitors Patient Safety Analysis reports to determine whether the principles of Being Open and the Duty of Candour have been followed appropriately in each case. The group is also responsible for identifying Trustwide learning and ensuring the rapid dissemination of this.

Compliance and activity regarding Duty of Candour is monitored by this group at every meeting by using the live report from Datix to identify what is outstanding and the plan to address completion and compliance.

5.12. Role of the Patient Safety Team

The Patient Safety Team are responsible for monitoring the review and investigation of patient safety incidents and maintain data quality and functionality of the Trust's Risk Management System (Datix) in terms of accurate recording and reporting of Duty of Candour.

The Patient Safety Team will ensure that resources such as templates and guidance on DoC are up to date and available for staff to use, all current templates for DoC letters can be found on the patient safety webpage http://intranet-rcht.cornwall.nhs.uk/brilliant-care/clinical-governance/patient-safety/ The information in the templates must be used but you can add any further information to personalise the letter, as appropriate, based on the conversation that the author of the letter has had with the person affected

The Patient Safety Team report a snapshot of the compliance figures for Duty of Candour on a monthly basis, this is to be included in the Trust Integrated Performance Report (IPR) and Performance Assurance Report (PAF) and through QAC.

6. Standards and Practice: Being Open and level of response

6.1. Initial assessment to determine level of response

All incidents should initially be discussed by the relevant clinical team to determine the level of response required. This will depend on the cause/s of the incident and the impact on the patient. The greater the impact on the patient and/or the more direct the effect of the treatment failures on the impact, the greater the response should be.

6.2. Notifiable Safety incidents

6.2.1. When a notifiable safety incident (with severity of moderate harm or above) has occurred, healthcare professionals (and their employer, the healthcare provider) must comply with the statutory duty of candour. They must:

- Acknowledge that an incident has occurred, reporting it appropriately to a senior member of staff in the department in which it occurred and on Datix.
- As soon as possible, after detection of the incident, inform the patient, family, or carer of the incident with a factual explanation of all known facts.
- **Offer a sincere apology –** this is not an admission of liability.
- Explain the possible consequences to the patient if not already evident, and any immediate or possible future health implications.
- Offer an appropriate resolution (if possible) and/or support to the patient, family, or carer.
- Explain any immediate steps taken to minimise or prevent the same incident recurring and that a more detailed investigation will take place.
- Let them know that a member of staff will follow up this initial discussion with more information after initial investigation.
- Follow up the verbal apology with a letter to the patient, family or carer detailing what was discussed, within **10 working days** of the incident being reported.

6.2.2 Where a PSR2 or PSII is required, the Investigating Officer will be provided with template letters on nomination.

6.2.3 They will follow up discussions with the patient, family, or carer as necessary to discuss:

- The final outcome of the investigation and the actions taken to prevent or limit recurrence.

- Explain any further steps for their care/treatment (if any).
- Answer any further questions.
- A copy of the final report will be sent on request to the patient, family, or carer with a covering letter; this should be reviewed and approved prior to sharing.
- Opportunity to ask further questions if desired will be given.

6.2.4 Staff involved in an incident, will be given all necessary support for as long as it is needed. All correspondence and verbal communications should be in plain language, not using technical terminology, to avoid misunderstanding or confusion.

6.2.5 Confidentiality and data protection will be maintained at all times. A Patient Information Leaflet is available to support conversations with patients and their families, explaining what the Duty of Candour is and what patients and their families should expect.

6.2.6 For Duty of Candour in the case of clinical imaging discrepancies, please refer to RCHT's Clinical Imaging protocol for the assessment and management of reporting discrepancies and Duty of Candour notification.

6.3. Low/no harm incidents

Low or no harm incidents do not require the same level of candour, however for any low or no harm incidents where a Patient Safety Review 1 (PSR1) is indicated or requested, a being open conversation should take place and recorded on Datix. Notify the patient about the incident as soon as possible with a factual explanation of all facts known at the time of the notification.

- Provide an apology.
- Explain fully the short and long-term effects of the incident.
- Offer appropriate support to put matters right (if possible).
- Explain the steps that will be taken to prevent recurrence of the incident (where relevant).
- Record details of the discussion in the patient's clinical record.

- For low-harm incidents the disclosure process can conclude here. This is a **being open** conversation.

6.4. Preliminary Team Discussion

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

- Establish the basic clinical details and other facts.
- Assess the incident and determine the level of immediate response.
- Identify who will be responsible for discussion with the patient and/or their carers.
- Consider the appropriateness of engaging patient support at this early stage.
- Identify immediate support needs for the healthcare staff involved.
- Ensure there is a consistent approach by all team members around discussions with the patient and/or their carers.

This can be in the form of a huddle, or governance meeting. In addition to this, it will be advantageous to provide facilities for formal and informal debriefing of the clinical team involved in the patient safety incident, where appropriate, and separate from the requirement to provide statements for the investigation. Staff may also benefit from individual feedback about the final outcome of the patient safety incident investigation.

6.5. Identifying the individual to communicate with the patient and/or their carers

6.5.1. The healthcare professional who informs the patient and/or their carers about a patient safety incident should be the most senior person responsible for the patient's care and/or someone with experience and expertise in the type of incident that has occurred. This could either be the patient's consultant or a senior member of nursing staff known to the patient, and/or Corporate Patient Safety Lead (if being investigated by the Corporate Patient Safety team). Consideration also needs to be given to the characteristics of the person nominated to lead the Duty of Candour / Being Open process. They should:

- Be known to, and trusted by, the patient and/or their carers.
- Have a good grasp of the facts relevant to the incident.
- Be senior enough, or have sufficient experience and expertise, in relation to the type of patient safety incident to be credible to patients, carers and colleagues.
- Have excellent interpersonal skills. This includes the ability to communicate with patients and/or their carers in a way they can understand. It is important to avoid excessive use of medical jargon.
- Be willing and able to offer an apology, reassurance and feedback to patients and/or their carers.
- Be able to maintain a medium to long-term relationship with the patient and/or their carers, where possible, and to provide continued support and information.

- Be culturally aware and informed about the specific needs of the patient and/or their carers.

6.5.2. **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. There should be repeated opportunities for the patient and/or carer to obtain information about the incident and many of the points raised here should be expanded on in subsequent meetings.

If for any reason it becomes clear during the initial discussion that the patient and/or carers would prefer to speak to a different health care professional, the patient's wishes should be respected. A substitute with whom the patient is satisfied should be provided.

6.6. Documentation

6.6.1. For all investigations to comply with the Duty of Candour regulations, there should be documentation of:

- Verbal conversations.
- The Duty of Candour letter, which is kept securely by the organization, either written or electronically on their patient record and/or on the Risk Management System (Datix).
- Progress notes relating to the clinical situation and an accurate summary of all the points explained to the patient and/or their carers with times and names of people involved.
- Copies of signed letters sent to patients, carers and the GP for patient safety incidents not occurring within primary care.
- Copies of any statements taken in relation to the patient safety incident.
- A copy of the incident report and evidence of this being shared with the patient or nominated person.

6.6.2. All correspondence should be held in accordance with the Trust's Records Management Policy. To evidence compliance with Being Open/Duty of Candour, staff must:

- Record the sharing of any facts that are known and agreed with the relevant person.

- Record how it has been agreed that the relevant person will be kept informed of the progress and results of that investigation.
- Record, where appropriate, a full apology to the patient and their family/carers and offer appropriate practical and emotional support.
- Record any explanation given of the likely short and long-term effects of the incident.
- Contain copies of any letters sent to the relevant person.

6.6.3. Electronic (Datix) Notification processes for incidents that trigger the Statutory Duty of Candour:

1. The healthcare professional who first discovers or is informed of the incident should inform their line manager and report the incident on Datix. The Datix report should accurately reflect the severity of harm.
2. For any incidents reported as moderate or above, the Patient Safety Team and other nominated staff for each Care Group and across the Trust (e.g., Infection Control) are informed of the incident by an automatic email generated by Datix.
3. Compliance with and completion of Duty of Candour must be within 10 days of the incident being identified and recorded on the Datix system. Evidence of compliance (in the form of the letter to the patient) must be uploaded to Datix, with the date this was sent and the name of the person who completed it. This forms the basis of monthly Duty of Candour completion and compliance reporting.

6.7 Reporting

6.7.1 On the first working day of the calendar month, the patient safety team, are responsible for providing Business Intelligence with the data, from the risk management system Datix, of the compliance with duty of Candour within the 10 working days of identification of the incident for those due in the month. The template for what is reported in the IPR can be seen in appendix 5.

6.7.2 The patient safety team will report the following data monthly in the IRLG QAC report.

Duty of Candour Reporting data
Number of incidents where DoC is indicated in month.
Number of Verbal DoC still outstanding in month (for relevant month and earlier) Target = 0
Number of Written DoC notifications still outstanding in month (for incidents that have had a verbal DoC) Target = 0

Duty of Candour Reporting data
% of incidents that are compliant with the requirement of DoC completed within 10 working days of incident reporting on Datix in month Target = 100%
Total % of incidents where Doc is completed Target =100% preceding month
Incident requiring DoC where a decision was made not to undertake. Review of each case for reasonableness

6.7.3 The IRLG report will contain narrative regarding any outlier to the established process for Doc to be completed within the 10 working days to allow for the identification of themes and learning for non-adherence to the process for compliance.

7. Dissemination and Implementation

7.1 Dissemination of this policy is via the Incident Review and Learning Group. Implementation is through the Care Group Management Teams who will ensure staff are aware of the policy. Care Group Management Teams will monitor the effectiveness of this policy's implementation and action change where concerns arise.

7.2 Duty of Candour training is a mandatory element of employee induction to the Trust and is included in the Trust mandatory training days. Enhanced training will be provided where required to those key members of staff who lead the Duty of Candour process. E-learning is also available to staff. Every member of the organisation must successfully complete this annually.

7.3 Support is available from Senior Clinicians, the Patient Safety Team, and Occupational Health. Clinical Directors, Heads of Nursing and Matrons will support staff involved in this process or can advise who they can contact for support.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Statutory Duty of Candour to include: 1. Verbal acknowledgment, apology, and explanation when things go wrong. 2. Continued communication with the patient, family or carer as required including a follow up letter and/or sharing the investigation findings within 10 working days from the incident being reported. Documentation /clear record of all communication.

Lead	Associate Director for Quality Governance.
Tool	Quarterly audit of Datix records.
Frequency	Audit of assurance recorded on Datix. Audit of a selection of patient notes and Datix records for those incidents where moderate harm has occurred, but the incident is not declared as a Patient Safety Incident or Review.
Reporting arrangements	The Board will receive assurance of compliance via the monthly Quality Assurance Committee and IPR.
Acting on recommendations and Lead(s)	Associate Director for Quality Governance.
Change in practice and lessons to be shared	Changes to practice will be identified and actioned within 3 months of being reported to the Quality Assurance Committee. A lead will be identified to take each change forward. Lessons will be shared with all the relevant stakeholders.

9. Updating and Review

9.1. The policy will be reviewed and updated no later than every 3 years or depending on change or development in legislation or regulations.

9.2. The Associate Director of Integrated Governance is responsible for nominating a suitable individual to complete reviews of this policy.

9.3. Any revision activity will be recorded in the version control table as part of the document control process.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion and Human Rights Policy' or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Being Open and Duty of Candour Policy V5.0
This document replaces (exact title of previous version):	Being Open and Duty of Candour Policy V4.0
Date Issued / Approved:	December 2024
Date Valid From:	March 2025
Date Valid To:	March 2028
Author / Owner:	Clinical Governance Team
Contact details:	01872 253281
Brief summary of contents:	Details the Trust's policy and procedure relating to Being Open in line with the NPSA's National Framework and the Statutory Duty of Candour.
Suggested Keywords:	Being open, candour, patient safety incident, duty, duty of candour.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Dual Chief Nursing Officer / Deputy CEO RCHT
Approval route for consultation and ratification:	Incident Review Learning Group Quality Assurance Committee
Manager confirming approval processes:	Bernadette George, Director of Nursing, Midwifery and Allied Health Care Professionals
Name of Governance Lead confirming consultation and ratification:	Esther Penrose, Head of Safety, Risk and Patient Experience
Links to key external standards:	Health and Social Care Act (Regulated Activities) Regulations 2014, Regulation 20: Duty of Candour. Good Medical Practice (GMC 2013).

Information Category	Detailed Information
	The Code: Professional standards of practice and behaviour for nurses and midwifery (Nursing and Midwifery Council; NMC, March 2015). HCPC (2018) Standards of Conduct, Performance and Ethics.
Related Documents:	Incident Management Policy Clinical Imaging protocol for the assessment and management of reporting discrepancies and Duty of Candour notification Complaints Policy. Supporting Staff Involved in an Incident, Complaint or Claim. Mortality review process/policy Claims Policy. Raising Concerns in the Public Interest (Whistleblowing) Policy.
Training Need Identified:	Yes - At Induction, mandatory training and Patient Safety Incident Response Framework training for Investigating Officers.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Patient Safety and Clinical Effectiveness

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
March 2007	V1.0	Final amendments approved; EIA Completed; document published	Debbie Blease, Deputy Director of Nursing
November 2010	V1.2	Review required for NPSA CAS Safety Alert NPSA-2009-PSA003 and NHSLA Standard 5. Updates and processes inserted with regard to staff support and named Executive and Non-Executive Director.	Teresa Anderson, Risk and Complaints Manager
May 2011	V1.3	Reformatted to comply with Policy on Policies	Andrew Rogers, Corporate Records Manager

Date	Version Number	Summary of Changes	Changes Made by
June 2013	V1.4	Changes to recording requirements para 15.	Joan Shirley, Risk Manager
December 2015	V1.5	Updated to reflect the new Statutory Duty of Candour requirements (and renamed).	Kate Boston, Divisional Quality Facilitator
October 2017	V.1.6	Revised. Additional paragraph to scope section - 3.4. Amends to Ownership and responsibilities sections: role of SIO and all staff. New section on documentary compliance. Amends to Appendices.	Debra Cooney, Governance Projects Lead
March 2018	V1.7	Simplification and edit of final draft prior to TMG approval. Changed Executive. Summary and Scope. Added reference to ESIRP. Added in Documentation (Datix) and Performance Management. Being Open Principles added.	John Taylor, Assoc Director Clinical Governance (Interim)
April 2018	V2.0	Minor amendments following consultation.	John Taylor, Assoc Director Clinical Governance (Interim)
January 2020	V3.0	Revised. Amendments following organisational restructure and strengthened compliance monitoring.	Aoife Cavanagh, Associate Director of Clinical Governance
December 2021	V4.0	Reviewed and revised in line with the Patient Safety Incident Response Framework.	Aoife Cavanagh, Deputy Director of Integrated Governance
August 2024	V5.0	Reviewed to update organisational and operational changes. Updated job titles and responsibilities. Removed previous appendix 3 and included hyperlink in section 1.8 instead. Reinforcing of the 10 day requirement from identification of the incident to complete Duty of Candour. The introduction of section 6.7 for reporting and appendix 5. Added for clarity the meaning of a working day.	Holly Kiernan, Head of Patient Safety

Date	Version Number	Summary of Changes	Changes Made by
		Confirmed that duty of candour letters can be personalized but the detail on the templates is mandated. The addition for governance leads to add to the incident management Datix system progress notes where duty of candour has been delayed to allow a review of themes and identify leaning.	

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Being Open and Duty of Candour Policy V5.0
Department and Service Area:	Quality, Safety and Compliance
Is this a new or existing document?	Existing policy
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Naomi Burden, Patient Safety Specialist and Lead for Safety Culture
Contact details:	01872 25 2279

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To promote and support a culture of openness, honesty and transparency following a patient safety incident. To ensure best practice in open communication with patients, their relatives and carers following a patient safety incident where a patient is harmed or there is potential for harm.
2. Policy Objectives	Compliance with Duty of Candour and Being Open requirements
3. Policy Intended Outcomes	Any patient harmed by the provision of healthcare whilst under the care of the Trust will be informed, receive an apology and offered appropriate remedy The Trust will be compliant with CQC Regulation 20: Duty of Candour
4. How will you measure each outcome?	See Section 8 Monitoring compliance and effectiveness
5. Who is intended to benefit from the policy?	Patients, carers and Staff

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Incident Review Learning Group
6c. What was the outcome of the consultation?	Agreed
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Naomi Burden, Patient Safety Specialist and Lead for Safety Culture.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Being Open Principles

The 10 Principles of Being Open - Being open involves apologising when something has gone wrong, being open about what has happened, how and why it may have happened, and keeping the patient and their family informed as part of any subsequent review.

1. **Principle of Acknowledgement**

   All patient safety events should be acknowledged and reported as soon as they are identified. In cases where the patient, their family and/or carers inform healthcare employees that something has happened, their concerns must be taken seriously and should be treated with compassion and understanding by all employees. Denial of a person's concerns or defensiveness will make future open and honest communication more difficult.

2. **Principles of Truthfulness, Timeliness and Clarity of Communication**

   Information about a patient safety incident must be given in a truthful and open manner by an appropriately nominated person. Communication should be timely, informing the patient, their family and carers what has happened as soon as is practicable, based solely on the facts known at that time. It will be explained that new information may emerge as the event investigation takes place. Patients, their families and carers and appointed advocates should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have.

3. **Principle of an Apology**

   Patients, their families, and carers should receive a meaningful apology - one that is a sincere expression of sorrow or regret for the harm that has resulted from a patient safety event or that the experience was poor. Both verbal and written apologies should be offered. Saying sorry is not an admission of liability and it is the right thing to do. Verbal apologies are essential because they allow face to face contact, where this is possible or requested. A written apology, which clearly states the organisation is sorry for the suffering and distress resulting from the patient safety event, should also be given.

4. **Principle of Recognising Patient and Carer Expectations**

   Patients, their families and carers can reasonably expect to be fully informed of the issues surrounding a patient safety incident, and its consequences, in a face to face (in person or 'virtual') meeting with representatives from the organisation and/or in accordance with the local resolution process where a complaint is an issue. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times. Patients, their families, and carers should also be provided with support in a manner to meet their needs. This may involve an independent advocate or an interpreter.

   Information enabling to other relevant support groups will be given as soon as possible and as appropriate.

Examples of further support:

Royal Cornwall Hospitals NHS Trust spiritual care The Chaplaincy is a confidential service available 24 hours a day, offering support in all aspects of spiritual and pastoral care to both members of all faiths or those of no particular religious belief. Telephone: 01872 252883 Email: mark.richards9@nhs.net

Healthwatch England – represents the views of patients and the public in health and social care. www.healthwatch.co.uk Telephone: 03000 683000

Support, Empower, Advocate, Promote (SEAP) – an independent advocacy service. www.seap.org.uk Telephone: 03304 409000 Carers UK – provides advice and support to carers and the people they care for. www.carersuk.org Telephone: 02073 784999

Cruse Bereavement Care – a national charity providing support to those having experienced the death of a close friend or relative. www.cruse.org.uk Telephone: 08088 081677

Action for Victims of Medical Accidents (AVMA) Provides free independent specialist advice and support to people when things go wrong in healthcare. www.avma.org.uk Helpline: 0845 123 2352

5. Principle of Professional Support

The Trust has set out to create an environment in which all employees are encouraged to report patient safety events. Employees should feel supported throughout the patient safety event investigation process; they too may have been traumatised by the event.

Resources available are referred to within the respective Trust policies, to ensure a robust and consistent approach to patient safety event investigation. Where there are concerns about the practice of an individual employee the Trust's Human Resources department must be contacted for advice. Where there is reason to believe an employee has committed a punitive or criminal act, the Trust will take steps to preserve its position and advise the employee at an early stage to enable them to obtain separate legal advice and/or representation. Employees should be encouraged to seek support from relevant professional bodies. Where appropriate, a referral will also be made to the Independent Safeguarding Authority.

6. Principle of Risk Management and Systems Improvement

The process as outlined in the Patient Safety Incident Response Framework (PSIRF), or similar techniques should be used to uncover the underlying causes of patient safety events. Investigations at any identified level will however focus on improving systems of care, which will be reviewed for their effectiveness.

Being open is integrated into patient safety incident reporting and risk management policies and processes.

7. Principles of Multi-Disciplinary Responsibility

Being open applies to all employees who have key roles in patient care. This ensures that the Being open process is consistent with the philosophy that patient safety incidents usually result from system failures and rarely from actions of an individual. To ensure multi-disciplinary involvement in the Being open process, it is important to identify clinical and managerial leaders who will support this across the health and care agencies that may be involved. Both senior managers and senior clinicians will be asked to participate in the patient safety incident investigation and clinical risk management as set out in the respective Trust policies and practice guidance.

8. Principles of Clinical Governance

Being open involves the support of patient safety and quality improvement through the Trust's clinical governance framework, in which patient safety incidents are investigated and analysed, to identify what can be done to prevent their recurrence. It is a system of accountability to ensure that these changes are implemented and their effectiveness reviewed. Findings are disseminated to employees so they can learn from patient safety incidents. Audits are an integral process, to monitor the implementation and effects of changes in practice following a patient safety incident.

9. Principle of Confidentiality

Details of a patient safety incident should at all times be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the patient. The Trust will anonymise any incident it publishes but still seek the agreement of those involved.

Where it is not practicable, or an individual refuses consent to disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the patient safety event have statutory powers for obtaining information. Communications with parties outside of those involved in the investigation will be on a strictly need to know basis.

Where possible, it is good practice to inform the patient, their family, and carers about who will be involved in the investigations before it takes place and give them the opportunity to raise any objections.

10. Principle of Continuity of Care

Patients will continue to receive all usual treatment and continue to be treated with respect and compassion.

Appendix 4. Quarterly spot-check audit template

Patient number	
Date of audit	
Name of auditor	

		Comments
Verbal candour has been completed	Yes ☐ ☐ No	
Follow up letter has been sent within 10 days of discovery of the incident	Yes ☐ ☐ No	If not 10 days, how many:
The written notification is compassionate and includes a sincere apology, which is tailored to the patient and incident (would you be satisfied if you were receiving this letter?)	Yes ☐ ☐ No	
The investigation findings have been shared with the patient (this can be included in the F/U letter if the details are know at this stage)	Yes ☐ ☐ No	
Copies of any written documentation relating to the incident/investigation have been uploaded to Datix	☐ Yes ☐ No	
Patients' medical records hold a written entry to confirm that the DoC process has been followed, this maybe the copy of the letter in maxims if the notes were not available to add the verbal written entry	☐ Yes ☐ No	
All fields within the DoC Section in Datix are completed	☐ Yes ☐ No	
Where DoC has not been completed in the 10 working days, the DoC Progress notes have been updated to reflect the reasons for the delay	☐ Yes ☐ No	
Recommendations from this audit		
Date of governance huddle where the findings of this audit have been shared		

Appendix 5 IPR Reporting template

Template to support the creation and sharing of quality metrics

The construction of metrics is not a straightforward task. There are many aspects of our services that we can collect data on, but not all of these are suitable to be metrics. What works for one situation or stakeholder may not be effective for another. Collection should not be potentially inconsistent or excessively burdensome. We need to be able to influence the future scores through our development and delivery of the service.

To help Library and Knowledge Service Managers to make better use of metrics this template offers both a structure to build your metric and a checklist of principles which make it effective. As you complete the template consider the guidance provided in italics (feel free to delete them once used) - you may not have to answer all of them and there may be other detail you wish to add. Review the checklist – this offers criteria which may further your thinking. Your completed template will provide you with a record that you can review regularly to ensure the metric remains useful. Elements of it can be shared with stakeholders to support engagement and provide assurance. You can modify this template or insert it into other documents as required.

Completing this template also offers a means to share your metric in such a way that others can learn from it and consider adaptation or adoption in their own setting. It has been tested by the Metrics Task and Finish group. A shared collection of metrics will be created from your submissions at http://kfh.libraryservices.nhs.uk/metrics-bank/

This template was informed by a model prepared by Grand River Hospital who have agreed our use. The principles for good metrics were developed by the Metrics Task and Finish group in their Principles for Metrics Report.

Metric Definition: *Give your metric a brief descriptive title. Try and explain it in a couple of lines.*

Duty of candour compliance

Why is it important? *How does it relate to strategies and business plans for the LKS, Trust or HEE? Which LQAF sections might it evidence? Who is the audience?*

CQC Regulation 20 - Statutory duty of candour including specific requirement for notifiable safety incidents. This regulation puts a legal duty on health and social care providers to be open and transparent with people using services and their families. It sets out actions that providers must take when a 'notifiable safety incident' happens.

Process for compiling the Metric: *Where does your data come from? Describe any limits or parameters applied to standard data sets. Include a link to any survey tools if applicable / possible. How often do you repeat the process? How would someone else go about repeating your metric?*

Data recorded on Datix by care groups. Trust wide data obtained from Datix by Patient Safety Manager and provided to Business Intelligence Team monthly for inclusion in the IPR.

- How many of the cases that met the threshold to require duty of candour, were completed within 10 working days of the incident (this includes both aspects of duty of candour, verbal and written).
- This metric only reports on cases that were due for completion in the month being reported on (i.e., previous month)
- Compliance reported as a percentage (i.e., percentage of cases that were due to be completed within the month being reported on, have actually been completed within the 10 working day limit)
- Any cases where duty of candour has been partially completed but not fully, does not meet definition of being compliant
- Compliance figures will not be amended retrospectively for previous months.
- This metric only reports on cases where the completion date for duty of candour falls within the month being reported on, not the total number of duty of candour cases that may be open at the time of reporting.

Ensure this template is shared with anyone who may be required to report on this metric in the absence of the usual data provider.

What does it mean? *How do you interpret this metric?* Compliance with duty of candour is calculated internally within the Trust as how many cases that met the threshold to require duty of candour, were completed within 10 working days of the incident (this includes both aspects of duty of candour, verbal and written). This metric only reports on cases that were due for completion in the month being reported on (i.e., previous month). Compliance reported as a percentage.	**Desired outcomes:** *What would improvement look like? Do you have a level you are required to reach or aiming for in a period? You might consider what would be Red, Amber, Green scores for a dashboard.* IPR target for 2024/25: 100%
Improvement plans: *How do you plan to make a difference to this metric in a defined period?* Compliance will be tracked through a live report shared at the weekly IRLG meeting to focus completion. The reasons for delays with compliance with duty of candour will be reported in the IRLG QAC report and any themes and trends with suggestions and actions for improvement with the metric will be shared with the IRLG group.	
Reporting: *Where and how do you plan to share the metric? Is it part of a dashboard or regular service monitoring report? You could embed a sample graph.* Metric reported monthly through Trust IPR.	
Data Quality: *Data Quality RAG score. Green: Data comes from a centrally owned system and should be subject to DQ checks. There are no known issues with the DQ, beyond generic risks such as poor data entry/ timeliness, large scale, and complexity etc. Amber: The data comes from a centrally owned system with overall DQ checks, but there are some known issues with the data; or the information comes from a non-centrally owned source but has been shown to be robust over time. Metrics in this category are often in the 'best available' category. Red: There are material issues with the data quality; it is subject to known potential inaccuracies. The measure should only be reported on a heavily caveated basis in the absence of any other data and in the knowledge of its limitations.* Green	

Data provider: *Who will provide the data? Who can be contacted to provide data in the absence of the usual data provider (include job title), ideally include at least 2 additional contacts.*

Usual data provider:

Jo Turner, Patient Safety Manager

joanne.turner22@nhs.net

Alternative data providers:

Zoe Saunders, Patient Safety Learning Facilitator

Zoe.saunders2@nhs.net

Deputy Risk Manager (TBC once recruited)

Checklist:

Does your metric meet the following criteria?

✓	**Meaningful** - does the metric relate to the goals of the organisation, to the needs of the users and is it re-examined over time for continuing appropriateness? Do other people care about it? Combining two facets can strengthen a metric – for example usage by a particular staff group.
✓	**Actionable** – is the metric in areas that the LKS can influence? Does it drive a change in behaviour? The reasons for changes to a metric should be investigated not assumed. Beware self-imposed targets – are they meaningful to stakeholders?
✓	**Reproducible** - the metric is a piece of research so should be clearly defined in advance of use and transparent. It should be able to be replicated over time and constructed with the most robust data available. Collection of data for the metric should not be burdensome to allow repetition when required.
✓	**Comparable** - the metric can be used to see change in the LKS over time. Be cautious if trying to benchmark externally. The diversity of services must be respected – no one metric fits all.