Joint Policy for Cumbria Partnership Foundation Trust & North Cumbria University Hospital NHS Trust

Being Open and the Duty of Candour Policy and Procedure

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Accountable Director	Joint Executive Director Nursing, Midwifery & AHPs
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Policy On A Page

SUMMARY & AIM

All staff must be aware of and apply the principles of being open and Duty of Candour. They must report incidents using their Trust's Ulysses Incident Reporting System. They must address incidents and respond to complaints as they arise in an open and honest way, offering an apology to patients, their families and carers.

This Policy provides a framework that will ensure Trust staff can fulfil the legal Duty of Candour and ensure that patients and their family receive open, accurate and timely communication when things go wrong with their care. This includes apologising for harm caused whilst in our care.

TARGET AUDIENCE:

All staff directly or indirectly involved in delivering health services.

Those staff involved in assessing the patient experience, responding to patient complaints, providing legal services in response to HM Coroner or patient injury claims and those involved in the investigation of Serious Incidents Requiring Investigation (SIRIs).

KEY REQUIREMENTS

1. We have a responsibility to be open and honest with all patients about errors and mistakes whilst they are in our care and apologise when this occurs.
2. The being open process applies to all patient safety incidents. For notifiable patient safety incidents that have, or may have, caused moderate harm, severe harm or death, the formal Duty of Candour process must be applied.
3. The Duty of Candour process must start within 10 working days of an incident being reported by notifying the "relevant person" (usually the patient) "face to face" that the incident has occurred, to apologise and to explain what happens next.
4. Following the "face to face" meeting and within 20 working days of the incident the "relevant person" (usually the patient) must be provided with a letter confirming what was discussed, that an investigation is underway and include an apology.
5. Subject to their wishes the findings of a completed investigation must be shared with the "relevant person" (usually the patient).
6. If any element of the Duty of Candour process cannot be completed the reasons must be recorded against the incident in Ulysses.
7. All Duty of Candour investigation reports, copy of letters, notes of discussions etc must be attached to the incident in Ulysses.

TRAINING:

Awareness training of the "Being Open" process as part of Corporate Induction is delivered on day one of employment to all staff

Level 1 (All staff) - Duty of Candour training to be undertaken via Trust workbook and e-learning package.

Level 2 - All managers and senior members of staff to attend face to face Duty of Candour Training.

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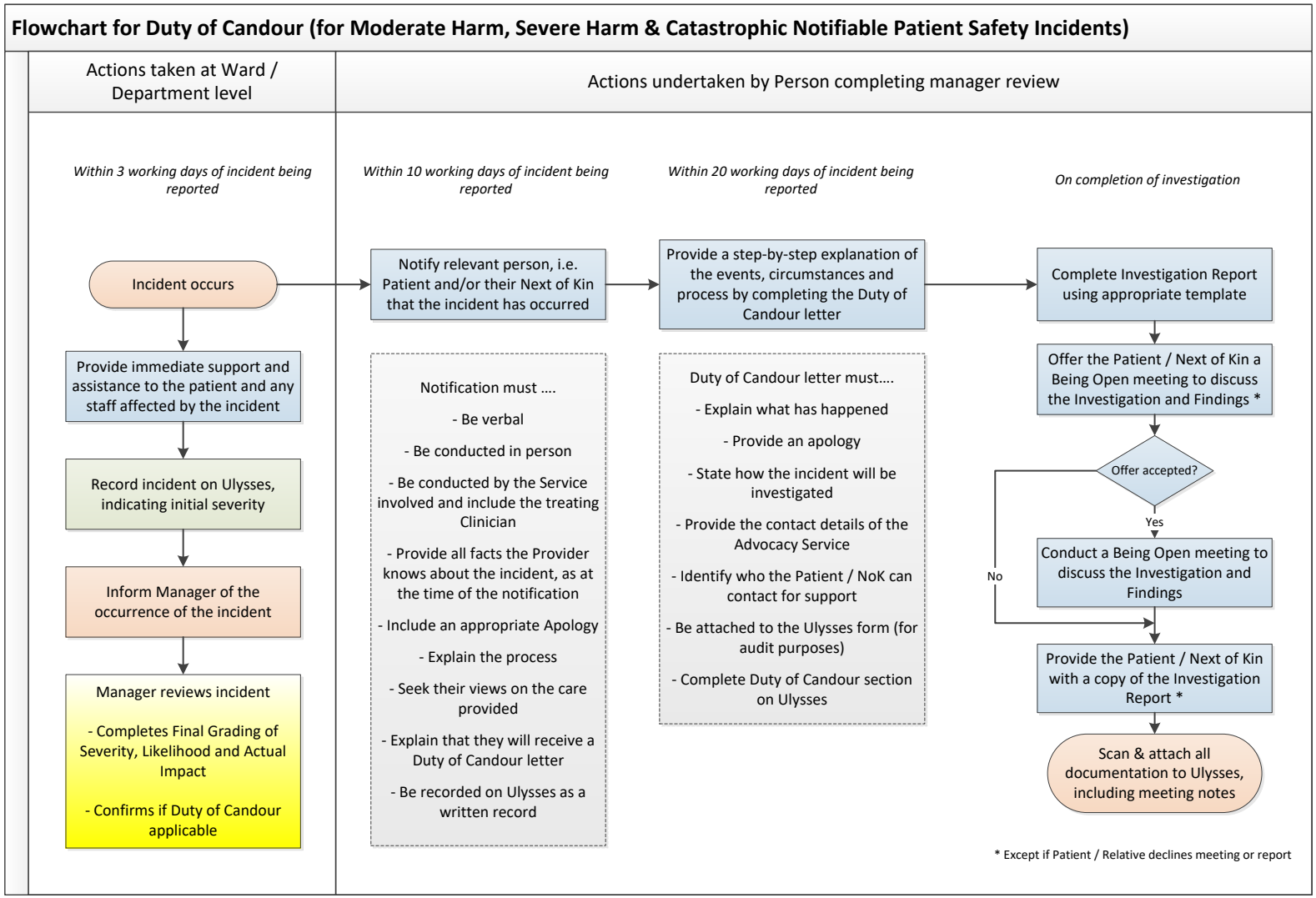
SUMMARY FLOWCHART:



1. INTRODUCTION

Every day Cumbria Partnership NHS Foundation Trust (CPFT) and North Cumbria University Hospitals NHS Trust (NCUHT) treat hundreds of patients in a safe and caring way. However there are occasions when things go wrong and unintended or unexpected harm is caused to patients whilst in our care. When this does occur all staff have the responsibility to be open and honest with patients, their families and carers.

Every healthcare professional, individually, must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.

The Care Quality Commissions Regulation 20 sets out the requirements for NHS Trusts. It requires staff to be open with patients and apologise when things go wrong that has, or may have, resulted in moderate or greater harm.

The Duty of Candour has applied to all registered providers of both NHS and independent healthcare bodies as well as providers of social care since 1st April 2015.

This policy is based on guidance from the Being Open Framework, National Patient Safety Agency (2009), Care Quality Commission Regulation 20 (March 2015), NMC/ GMC – Professional Duty of Candour, and NHS Standard Contract 2018/19.

The Summary Flowchart on page 5 sets out the process, outputs and timescales to be followed. Further explanation is set out over the following pages.

2. PURPOSE

The purpose of this policy is to provide a framework for all staff to follow when incidents / harm occurs to patients whilst in our care. It outlines the process staff should follow when being open with patients and confirms the process to comply with the Care Quality Regulation 20, Duty of Candour.

3. POLICY DETAILS

3.1 Being Open

3.1.1 Being Open means that we will in all cases be open with patients, their families and carers when they have suffered unintended or unexpected consequences as a result of their care or treatment which has resulted in a level of harm. As Trusts' we fully adopt the National Patient Safety Agency principles of being open with patients about their care and treatment, which is about adopting an overall process not a one off event.

3.1.2 The level of harm caused to patients will define the nature of the response required across the Trusts. If there is a near miss, no harm or low harm then then

staff should "Be open" by speaking to the patient at the time and record this in the clinical record. It is only when the harm is moderate or greater and it is a notifiable patient safety incident, that the "Duty of Candour" is triggered. There will be incidents reported on the Ulysses system that are correctly assessed as "moderate" but that are not notifiable patient safety incidents. As such the Duty of Candour will not apply.

3.2 Determining the level of harm

3.2.1 Once an incident is reported, the reporter will indicate what they judge to be the severity of the incident. All incidents reported are sent to the relevant manager to review. The review of the incident by the manager is where the severity is confirmed and the actual level of harm. For all notifiable patient safety related incidents, the actual level of harm sets out the level of investigation to be completed. This includes when incidents are escalated to be Serious Incidents.

3.2.2 The Trusts' Incident Management Policies set out in detail the process for reporting and investigating incidents. The Table below summarises the level of investigations and where the formal Duty of Candour must be applied.

Level of Harm	**Level of investigation for notifiable patient safety incidents**	**Does Duty of Candour apply?**	**Investigation templates which could apply**
Near Miss	Near miss	No – but being open principles always do	Ulysses system updated on how learning will be shared
No harm	Low	No – but being open principles always do	Ulysses system updated with outcome of investigation recorded
Low harm *	Low	No – but being open principles always do	Ulysses system updated with outcome of investigation recorded
Moderate **	Moderate	Yes	• CPFT 72 hr Root Cause Analysis (RCA) report • NCUHT RCA Reporting Template/ Falls RCA/ Pressure Ulcer RCA
Major (severe) ***	Serious	Yes	• CPFT 72 hr RCA report • RCA Reporting Template • Level 1 – Concise • Level 2 – Comprehensive
Catastrophic ****	Serious	Yes	• CPFT and NCUHT 72 hr RCA report • RCA Reporting Template • Level 1 – Concise • Level 2 – Comprehensive

* Minor treatment is defined as first aid, additional therapy, extra observations or additional medication. It does not include any extra stay in hospital or any extra time as an outpatient, or continued treatment over and above the treatment already planned; nor does it include a return to surgery or readmission.

** Moderate increase in treatment is defined as a return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another area such as intensive care

*** Major (severe) harm is directly related to the incident and not related to the natural course of the patient's illness or underlying condition. This is defined as permanent lessening of bodily functions, sensory, motor, physiological or intellectual, including removal of the wrong limb or organ, or brain damage.

**** Catastrophic relates to the death of a patient. The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition. The mortality review of cases are completed for deaths in each Trust in line with their respective mortality review policies.

3.2.3 It is important to highlight that there may be occasions when the initial incident reported requires clinical review in order to determine the actual level of harm as opposed to the natural course of the patient's illness or underlying condition. This would usually be undertaken, either individually or collectively, by a senior operational manager, a quality and safety lead, a matron, chief matron, associate director of nursing, associate medical director and / or clinical lead/director and Governance facilitators reviewing the initial investigation findings, including the timeline of events.

3.3 Duty of Candour

3.3.1 When does this apply?

The decision as to whether the Duty of Candour threshold is reached is not a simple one. It is a matter of judgement that needs to be exercised on a case by case basis to determine whether an incident is actually a "notifiable patient safety incident" that has (or may have) resulted from something that has gone wrong in the health care provided and the harm caused is properly assessed as moderate harm or greater. However, if in doubt, the default should be to apply the Duty of Candour process.

When a notifiable patient safety incident is confirmed to have caused moderate harm, severe harm or death, the formal Duty of Candour process must be followed, as set out in the Flowchart on page 4.

3.3.2 What is the formal Duty of Candour Process?

a) <u>Immediately after the incident</u>

Provide support to the patient, their families or carers after the incident. This should include reducing any potential for further harm. Ensure any relevant information is recorded in the patient's medical notes as part of their contemporaneous record of care and treatment for this episode of care.

Complete the Ulysses incident form and inform your manager about the incident in accordance with the Trust's Incident Management Policy.

b) Within 72 hours/ 3 working days of the incident being reported

The manager should complete their manager review of the incident on Ulysses and confirm the level of harm. This may be confirmed following multi-disciplinary review of the case in order to confirm that it is a "notifiable patient safety incident", the actual level of harm caused and the level investigation to be carried out.

If it is confirmed that it is both a "notifiable patient safety incident", and that it has, or may have resulted in moderate harm or greater, then the appropriate investigation report needs to be completed:

- CPFT: 72 hr Root Cause Analysis (RCA)/ brief clinical review report
- NCUHT: RCA Reporting Template/ Falls RCA/ Pressure Ulcer RCA

c) Within 10 working days of the incident being reported

Once the level of harm has been confirmed the manager or lead identified (this may be the lead clinician for the patients care) must meet "face to face" with the "relevant person" (usually the patient but if not possible or appropriate, the next of Kin or person acting lawfully on their behalf) and explain:

- That the incident has occurred
- Provide an account to the best of their knowledge of all the facts of the incident as at the date of the notification
- Advise on the further enquiries which are to be undertaken as part of the investigation
- Include an apology

The patient's/ others views of the care provided should also be sought, together with any questions that they may have, so that they can be used to inform the investigation and the issues to be addressed.

The manager must ensure that the Ulysses Duty of Candour section has been updated as the written record of the initiation of the Duty of Candour process. The Ulysses system is the main system for recording information, however it is accepted that immediate information may also be written in the patient's notes as part of their contemporaneous record of care by the lead clinician.

It is also important that the patient or lawful representative is supported in relation to where they can go to for additional help (by providing them with the contact details of an advocacy service) or emotional support.

d) Following the "face to face " meeting, and within 20 working days of the incident, the information provided must be confirmed in writing to the "relevant person" (usually the patient but if not possible or appropriate, the, next of Kin or person acting lawfully on their behalf)

The verbal notification must be followed up in writing within 20 working days of the incident. The written notification must include:

- All the facts of the incident as at the date of the notification (previously outlined in person at the "face to face" meeting.
- The contact details for the advocacy service.
- An explanation that an investigation is underway and the planned timescales for its completion.
- The name of the lead person and their contact details.
- An apology.

The Trusts' 'Letter Template for Duty of Candour Written Notification' must be completed (which is attached at Appendix 1 of this policy. Whilst the component parts of the template letter must be retained, the letter should be tailored to ensure that it is appropriately personalised. The written notification must be attached to the original Ulysses incident form as part of the written record and correspondence with the patient.

There are two patient information leaflets available for including with the letter. Which one to provide depends upon the circumstances; "Being Open: Guide for patients and families" or "Information to support to Family and Friends following an Unexpected Death". These can be downloaded from the respective clinical governance intranet sites.

Section 3.4 below explains that in certain circumstances it is important to recognise when communication with patients, their families or representatives may need to be modified.

e) Upon completion of the investigation and report finalised

Following completion of the investigation and the approval and finalisation of the report, the identified lead must contact the patient in order to agree how the findings of the investigation will be shared with them.

If the "relevant person" (usually the patient but if not possible or appropriate, the, next of Kin or person acting lawfully on their behalf) explains that they do not wish to be advised of the findings then their wishes should be respected. This should be recorded against the incident in Ulysses.

In most cases patients will be sent a copy of the completed investigation report and a meeting will be held to discuss the findings and answer any questions the patient

and or their family may have about what has happened. However, dependent upon the findings, it may be appropriate to provide the report at the meeting to allow staff to both explain the findings and support the patient/relatives.

If it is felt that sharing the findings with the patient poses a risk to their safety then this needs to be discussed and agreed between the relevant managers and, wherever possible, an alternative "relevant person" identified. Again, these considerations and agreed actions must be documented in Ulysses.

3.3.3 If a patient cannot be contacted or declines to speak to the identified lead about the incident

We need to take reasonable steps to contact a patient or their carer / representative. If they cannot be contacted in accordance with the process set out in this policy a written record on Ulysses is to be kept of all the attempts to contact the person(s), including dates and times.

We need to respect the wishes of the patient or their representative if they do not wish to be informed of the details of the incident or the findings from the investigation. If they decline to speak to the identified lead regarding the incident and/ or do not wish to be informed of the findings from the investigation a written record on Ulysses is to be kept explaining this.

3.3.4 Complaints

Whilst the majority of Duty of Candour notifications will relate to Patient Safety Incidents that have been reported by staff at the time using Ulysses, Duty of Candour will also apply where an investigation into a complaint has identified that it is a notifiable patient safety incident that has caused moderate or greater harm.

3.4 Special Considerations

It is important to recognise when communication with patients, their families or representatives may need to be modified. This could include for example:

- When a patient has died
- Where a patient has a cognitive impairment and or may lack capacity
- Patients with a different language or cultural considerations
- Patients with different communication needs
- Children
- Where there is a corresponding criminal enquiry or external agency involvement such as the Police.

In any of these or other instances, the lead identified for the Duty of Candour process should agree and document where communication has been modified and additional support put in place. This should be done in conjunction with associated relevant policies or procedures, for example accessing interpreters.

3.4.1 Criminal or Intentional Unsafe Act

Patient safety incidents are almost always unintentional. However if, at any stage following an incident, it is determined that harm may have been the result of a criminal or intentional unsafe act, this must be escalated immediately to the line manager, quality and safety lead, Associate Director of Nursing and/ or Associate Medical Director. If felt appropriate it can also be reported directly to the Executive Director of Nursing and/ or an Executive Medical Director.

3.5 Multi-disciplinary Team (MDT) Discussion & Duty of Candour Lead

Following identification of the incident the multidisciplinary team, including the most senior healthcare professional involved in the incident, must meet/communicate as soon as possible to:

- establish the basic facts
- assess the incident to 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. This includes the use of a facilitator, a patient advocate or a healthcare professional who will be responsible for identifying the patient's needs and communicating them back to the healthcare team
- identify immediate support needs for the healthcare staff involved including team de-briefing and individual support
- establish a process for collation of evidence on the investigation
- complete the 72 hr RCA or other template report.

The level of the multi-disciplinary meeting/communication will depend on the nature of the incident and its seriousness. It is important that delays to involve members of the multi-disciplinary team are minimised and or escalated for resolution where necessary.

They must also agree how the Trust Duty of Candour process will be implemented and the relevant leads, including the most senior / relevant person to speak with the patient. They must:

- have a clear understanding of the facts relevant to the incident
- be senior enough or have sufficient experience and expertise in relation to the type of patient incident to be credible to patients, carers and colleagues
- have excellent interpersonal skills, including being able to communicate with patients and/or their carers in a way they can understand and avoiding 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.

3.6 Level of investigation

The majority of severe harm and all catastrophic incidents are likely to be declared as a serious incident requiring investigation (SIRI) and follow the Trusts' process for investigating serious incidents, which includes completing a Root Cause Analysis (RCA).

Where patient safety incidents are confirmed as moderate level of harm, these incidents will normally be investigated locally within the specialty/ service and the relevant investigation and reporting template used (CPFT: 72 hr Root Cause Analysis (RCA)/ Brief Clinical review report, NCUHT RCA Reporting Template/ Falls RCA/ Pressure Ulcer RCA). It is important to note that some moderate incidents may also be escalated as a serious incident depending on the outcome of the initial review of harm and contributory factors.

Further information is included in the Incident Management Policy and training package for Level 2 – Duty of Candour Training.

3.6.1 Guidance on meetings to share the findings of investigations

Meetings to discuss the findings of investigations with the patient and/ or their carers/ relatives, must be conducted and recorded in accordance with Appendix 2. The record of the meeting must be attached to the Ulysses incident as part of documenting all correspondence with the patient.

3.7 Record keeping

It is important that the documentation of all communication in relation to the Duty of Candour process is kept. The Ulysses system and attaching information to the original incident is the main source where information must be recorded. However, a template is also attached at Appendix 3 of this policy as a working tool for staff leading on Duty of Candour in order to keep contemporaneous records of communication which can be attached to the Ulysses system following completion of investigations.

4. TRAINING AND SUPPORT

- Awareness training of the "Being Open" process as part of Corporate Induction is delivered on day one of employment to all staff
- Level 1 - Awareness training for all staff – via e-learning package.
- Level 2 - Ward Managers, Business Managers, GMs, Band 6 shift leads, Heads of Department, Governance Facilitators, Lead Learning Lessons Facilitators, Matrons and Clinical Directors face to face Duty of Candour Training.

The Trusts' intranet pages for Duty of Candour contain supporting information on all appendices referred to in this policy and relevant national guidance.

5. PROCESS FOR MONITORING COMPLIANCE

The process for monitoring compliance with the effectiveness of this policy is as follows:

Monitoring/audit arrangements	Methodology	Reporting		
		Lead	Committee	Frequency
Governance Facilitators'/ Incident & Risk Team provide monthly Duty of Candour Performance reports to each care group (or through the Quality and Safety Dashboard) for those incidents where it is has been confirmed that the duty of candour is to be applied.	Report ran from Ulysses to monitor performance.	Lead Governance Facilitator Care Group Associate Operational Managers	Exceptions reported to Care Group Clinical Governance Meetings Compliance against DOC to be reported to S&Q/JTWCGG	Monthly
Six monthly internal compliance spot check audit.	Random selection of 10 moderate and 10 severe harm incidents to check process and evidence in place	Lead Learning Lessons Facilitator/ Governance Facilitator	Reported to Care Group Clinical Governance Meetings	Six monthly
Mandatory training compliance monitoring.	Monitor level 1 and level 2 mandatory training	Care Group Associate Operational Managers	Safety & Quality Committee JTWCGG	Annually

<u>Wherever the above monitoring has identified deficiencies, the following must be in place:</u>

- Action plan
- Progress of action plan monitored by the relevant committee minutes
- Risks will be considered for inclusion in the appropriate risk registers.

6. REFERENCES:

NPSA (2009) "Being Open" – Communicating patient safety incidents with patients and their families

Care Quality Commission – Duty of Candour Regulation 20

7. ASSOCIATED DOCUMENTATION:

- Incident and Serious Incident Investigation Policy (CPFT)
- Incident Management Policy (NCUHT)
- Risk Management Policy (for levels of harm) (NCUHT)

8. DUTIES (ROLES & RESPONSIBILITIES):

8.1 Chief Executive / Trust Board Responsibilities:

The Chief Executive and Trust Board jointly have overall responsibility for the strategic and operational management of the Trust, including ensuring that Trust policies comply with all legal, statutory and good practice requirements.

The Chief Executive has the ultimate responsibility for ensuring that there is a culture of openness and support for both patients and staff when an incident occurs in the Trust.

8.2 Executive Director Responsibilities:

All policies have a designated Executive Director and it is their responsibility to be involved in the development and sign off of the policies, this should ensure that Trust policies meet statutory legislation and guidance where appropriate. They must ensure the policies are kept up to date by the relevant author and approved at the appropriate committee.

8.2.1 Joint Executive Director Nursing, Midwifery & AHPs

This person provides clinical leadership and will ensure that advice, training and support mechanisms are in place for staff in respect of the patient safety incidents and the process of being open with patients from a medical, nursing, midwifery and Allied Health Professional's perspective.

8.2.2 Joint Associate Director of Quality Governance

This person also provides clinical leadership and will ensure that advice, training and support mechanisms are in place for staff in respect of the patient safety

incidents and the process of being open with patients from a medical, nursing, midwifery and Allied Health Professional's perspective. They will also support the care groups in the design and the provision of an appropriate infrastructure for staff involved in patient safety incidents and in the reporting of compliance with this Policy.

8.2.3 Care Group Associate Operational Managers

These people will support the Joint Executive Director Nursing, Midwifery & AHPs, Joint Associate Director of Quality Governance, and the Care Groups in the provision of an appropriate infrastructure for staff involved in patient safety incidents, including those staff that are responsible for leading being open discussions. In addition they will ensure the status of compliance with the Duty of Candour is included and reported to the Joint Trust Wide Clinical Governance Group and the Safety and Quality Committee.

8.3 Managers Responsibilities:

8.3.1 Care Group Associate Medical Directors, Care Group Associate Directors of Nursing, Clinical Directors, Matrons, Quality and Safety Leads, Heads of Departments, Ward Managers, Team Leaders

These staff members are responsible for the promotion of the being open culture and compliance with the Duty of Candour process within their areas. In addition they will ensure that the most appropriate senior staff member is identified to meet with the patient and relatives. They will give consideration to the characteristics of the person nominated to lead the being open process, ensuring that lead is senior enough or has sufficient expertise in relation to the type of patient safety incident.

8.3.2 Associate Operational Managers, General Managers and Business Managers

These staff members are responsible for cascading this policy and ensuring its implementation across their services/specialties. The Clinical Divisions are responsible for monitoring the application of Duty of Candour as part of its clinical governance reporting and reviewing of serious and moderate harm related incidents.

8.3.3 Governance Facilitators, Clinical Risk and Safety Manager

The Governance Facilitators or the Clinical Risk and Safety Manager are responsible for the monitoring of the quality controls being applied in order to comply with this policy. This includes ensuring that the Ulysses Risk management system is up to date for their Care Group (s) in relation to Duty of Candour and reviewing the weekly performance of incidents reported and awaiting 'manager review'.

8.3.4 Complaints Manager/ Patient Experience Manager

The Complaints Manager/ Patient Experience Manager are responsible for co-ordinating or ensuring that any Duty of Candour notifications are triggered from a complaint investigation.

8.4 Staff Responsibilities

All staff must be aware of and apply the principles of being open and Duty of Candour. They must report incidents using the Trust Ulysses Incident reporting System. They must address incidents and respond to complaints as they arise in an open and honest way offering an apology to patients, their families and carers.

8.5 Approving Committee Responsibilities:

The Chair of the approving committee will ensure the policy approval is documented in the final section of the Checklist for Policy Changes. The committee will agree the approval of the final draft of the policy.

The Safety & Quality Committee/ Joint Trust Wide Clinical Governance Group will monitor the assurance / evidence in place regarding compliance with Duty of Candour.

9. ABBREVIATIONS / DEFINITION OF TERMS USED

ABBREVIATION	DEFINITION
JTWCGG	Joint Trust Wide Clinical Governance Group
RCA	Root Cause Analysis

TERM USED	DEFINITION
Candour	The state or quality of being open, honest, frank and sincere.
Moderate harm	Harm that requires a moderate increase in treatment, or significant harm which is not permanent.
Moderate increase in treatment	An unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancellation of treatment, or transfer to another treatment area, such as ICU.
Notifiable patient safety incident	Any unintended or unexpected incident that occurred during the provision of a regulated activity that did or could result in death or harm to a Patient. These are referred to as patient safety incidents in this policy.
Prolonged pain	Means pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

TERM USED	DEFINITION
Prolonged psychological harm	Psychological harm which a service use has experience, or is likely to experience, for a continuous period of at least 28 days.
Relevant Person	The regulation defines the relevant person as the person using the service and, in certain situations, extends to people acting lawfully on their behalf. The patient may request that a suitable person acts on their behalf. This can include where the service user is under the age of 16 or where they lack the capacity in relation to the matter.
Severe harm	A permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb, organ or brain damage.

APPENDIX 1 - WRITTEN NOTIFICATION OF DUTY OF CANDOUR

Use CPFT or NCUHT Logo as appropriate

Address
Address
Address

Date

Ref: (Incident Reference)

Address
Address
Address

Dear *Patient or Carer/Representative*

As you know you met with ????? on date ? who explained that You/Your ……. (Insert relative) have/has been involved in a patient safety incident, which related to (brief description) .....on (date). At that meeting I/ it was explained that we would follow up with an explanation in writing. That is the purpose of this letter.

Once again I wish to express my sincere regret and apologise for the harm you/your (insert relative) may have suffered whilst in our care. In order to ensure we learn from what has happened we will be obtaining further information and completing an investigation which is summarised below in order to determine what has happened.

In order to determine what happened to you/your…… we are investigating *(summarise the key points which are being looked into):*

As part of the investigation the investigator may contact you/ your relative (amend as appropriate) to discuss the care that you received leading up to the incident.

When our investigation is complete you will be contacted to confirm that you do wish to received feedback and agree how best we share the findings of the investigation with you.

We recognise that this may be a distressing time for you, if you have any questions or feel you need additional support at this time please do not hesitate to contact the identified lead outlined below. Alternatively there is an independent advocacy service available “People First” to support and assist you in this who can be contacted on 03003 038 037.

Please be assured that it is not our intention to intrude upon you or your family at what may be a difficult time, however, it is important we keep you informed about the care that we have provided. If you do not wish to be involved any further then just let us know.

At this stage I/ Staff member XXXXX is acting as your lead contact for the duration of this process and can be contacted on tel: XXX.

Yours sincerely

(Job title)

Manager (Name and Position)

Attached: ; "Being Open: Guide for patients and families" or "Information to support to Family and Friends following an Unexpected Death".

APPENDIX 2 - TEMPLATE FOR CONDUCTING A BEING OPEN MEETING

On completion of an investigation into a moderate, serious or incident involving death, arrangements must be agreed with the patient and or family in relation to sharing the findings of the investigation report. This process in the organisation is called a being open meeting. It should be noted that there are occasions where patients and or their families may not wish to meet with the Trust to discuss the findings, which must be respected. Arrangements must be made to ensure the patient and or the family receives a copy of the investigation report and advice can be obtained from the clinical governance department on this.

Patient Name: **NHS Number:**	**Date of Incident:**	**Ulysses number:**
Ward / Department:	**Nominated staff lead for this incident:**	
Is this incident an SI?		
Present at the Being Open Meeting:		**Date of Meeting:**

Summary of the incident (summarise what happened and how this happened)
Summarise the key learning points from this investigation and any recommendations/actions

Has a copy of the completed incident investigation report been shared with the patient and or family? Yes/No (If not/ why not?)
Does the patient and or family have any questions or concerns which have not been fully addressed?
What are the arrangements to address these additional concerns or offer further support?
Notes / Further comments:

APPENDIX 3 – BEING OPEN RECORDS / DOCUMENTATION

TEMPLATE FOR KEEPING UP TO DATE RECORDS

NAME OF PATIENT:	**INCIDENT DATE:**	**LEVEL OF INVESTIGATION** *(MODERATE OR SERIOUS)*
LEAD FOR INVESTIGATION:	**INITIAL TIMEFRAME FOR COMPLETION (PLEASE INCLUDE ANY CHANGES)**	

Date	Who was present	What was discussed

DOCUMENT CONTROL

Equality Impact Assessment Date	31 July 2018
Sub-Committee & Approval Date	

History of previous published versions of this document:

Trust	Version	Ratified Date	Review Date	Date Published	Disposal Date
CPFT	POL/001/ 040	26/4/2016	May 2018	28/4/2016	
NCUHT	RM02 v8.0	15/11/2016	November 2018	20/1/2017	

Statement of changes made from previous version

Version	Date	Section & Description of change
V0.1	9/7/2018	This is a new joint policy for CPFT and NCUHT on a new policy template so the changes are too numerous to document.
V0.2	31/7/2018	Amendments made to address issues raised from consultation

List of Stakeholders who have reviewed the document

Name	Job Title	Date
Presented to Joint Trust Wide Clinical Governance Group on 17 July 2018. Comments sought by 27 July 2018.		