# EXPECT GROUP OF COMPANIES

## DUTY OF CANDOUR AND BEING OPEN

### Scope

This document sets out Expect's approach to being open and the Duty of Candour. It applies to all staff employed by Expect.

**Related Expect Documents**

MA002 Complaints
MA004 Confidentiality
QMP017.1 Duty of Candour – Staff Briefing
QMP017.2 Implications of Not Implementing the Duty of Candour
"Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England".

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**EXPECT GROUP OF COMPANIES**
**BEING OPEN AND DUTY OF CANDOUR POLICY**

## 1 AIMS

1.1 To ensure that Service Users are told when harm occurs as a result of the care/support they receive.

1.2 The Duty of Candour duty is made a reality for people who come into contact with Expect's services.

1.3 There is clear, organisational encouragement for staff to follow their ethical responsibility in being open and honest with Service Users.

1.4 There is unequivocal, sustained support for staff in reporting incidents and in being open.

1.5 The Service User's right to openness from Expect is clearly understood by all staff.

1.6 Expect learns from mistakes with full transparency and openness.

1.7 Service Users and their families and carers trust Expect to share information with them in an open and collaborative way.

1.8 Expect works in partnership with others to protect Service Users.

## 2 STANDARDS OF EXCELLENCE

2.1 Since April 2015 Expect has, had a statutory Duty of Candour to ensure every member of Expect's staff is open and honest with Service Users.

2.2 All new employees are made aware of the 'Being Open' process and Duty of Candour as part of their induction programme.

2.3 The Being Open principles and ethical duty of openness apply to all incidents and any failure in care or support.

2.4 Expect will ensure that Service Users are told when harm occurs as a result of any failure in the care they receive.

2.5 The Duty of Candour applies to incidents whereby moderate harm, significant harm or death has occurred and may be applied where a complaint has be made against Expect.

2.6 Each incident is judged on a case by case basis.

2.7 Where necessary, apologies are given to those who have been harmed or suffered as a result of the incident.

2.8 It is acknowledged that support and care is not risk free. Service Users, families and carers usually understand this, and want to know not only that every effort has been made to put things right, but every effort is made to prevent similar incidents happening again to somebody else**.**

2.9 Expect's approach to candour underpins a commitment to providing high quality of care, understanding and sharing the truths about harm at an organisational as well as an individual level, and learning from mistakes and failures.

2.10 The processes contained within this policy reflect those set out in Regulation 20 and in the associated CQC guidance.

2.11 Potential implications of not following the Duty of Candour are shown in appendix 1.

## 3 DEFINITIONS

3.1 **Relevant Person:** The regulations use the term, "relevant person" when describing the person who will be informed of an incident in the Duty of Candour process. This may be the Service User, or a person lawfully acting on their behalf.

3.2 **Being open:** was described by the National Service User Safety Agency in 2009 as 'discussing Service User safety incidents promptly, fully and compassionately.

3.3 **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'.

3.4 **A Service User Safety Incident:** is defined as 'Any unintended or unexpected incident that could have or did lead to harm for one or more Service Users receiving care or support during the provision of a regulated activity, that may have caused:

(a) the death of the Service User, where the death relates directly to the incident rather than to the natural course of the 's illness or underlying condition, or

(b) severe harm, moderate harm or prolonged psychological harm to the Service User. "Prolonged psychological harm" means psychological harm which a Service User has experienced, or is likely to experience, for a continuous period of at least 28 days."

3.5 **Serious Incident:** A serious incident is defined as an incident that occurred which resulted in one or more of the following:

- Unexpected or avoidable death or severe harm of one or more Service Users, staff or members of the public;
- A never event - all never events are defined as serious incidents although not all never events necessarily result in severe harm or death;
- A scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;
- Allegations, or incidents, of physical abuse and sexual assault or abuse;
- Loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

It is important to note that a Serious Incident is not necessarily the same as a Duty of Candour notifiable incident, although there will be some cases where a serious incident is also a notifiable incident.

3.6 **Notifiable Incident:** This describes an incident that needs to be notified to the Service User and/or their carer/family under the Duty of Candour. A notifiable incident and a serious incident are not necessarily one and the same.

## 4 MAKING A JUDGMENT

4.1 Regulation 20 requires the judgement whether an incident is notifiable, is to be down to the opinion of the member of staff involved, in consultation with their line manager. Any decision made regarding notification by the member of staff must be clearly documented in the Service User's notes, demonstrating clear rationale for the decisions.

4.2 Each judgment needs to be exercised on a case by case basis to determine whether a notifiable incident has occurred. What may or may not appear to be an incident at the outset may look very different once more information comes to light, and may therefore mean an incident becomes notifiable under the Duty of Candour.

4.3 If, after using professional judgement, there is uncertainty about whether the incident is notifiable then the Service User should be fully informed of the facts, and should be kept informed until the conclusion of the episode.

4.4 Where the degree of harm is not yet clear but may fall into the moderate or above categories, then the relevant person must be informed. It also may not be clear whether the incident or harm was as a result of the care the Service User received. Any decisions made, and the outcome of the decisions, must be recorded in the Service User's notes.

## 5 HEALTH AND SOCIAL CARE ACT 2008

## (Regulated Activities) Regulations 2014: Regulation 20

5.1 The intention of Regulation 20, is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that Expect must follow

when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

5.2 The regulation applies to registered persons when they are carrying on a regulated activity.

5.3 The CQC can prosecute for a breach of parts 20(2)(a) and 20(3) of this regulation and can move directly to prosecution without first serving a Warning Notice. Additionally, the CQC may also take other regulatory action.

## 6 RESPONSIBILITIES

6.1 **Expect's Board of Trustees:** The Board fully endorses the principles of being open and actively promotes an open, honest and fair culture. Expect's Board will seek assurances that the principles and processes set out in this policy work effectively to support the commitment to implementing the Duty of Candour.

6.2 **Chief Executive Officer:** The Chief Executive is ultimately responsible for the process of managing and responding to the being open/Duty of Candour process and for the delegation of this role as required.

6.3 **Senior Management Team:** The Senior Management Team are responsible for actively supporting the Chief Executive with being open and the Duty of Candour principles and process.

6.4 **Line Managers' Responsibility:** It is the responsibility of all of Expect's managers to support employees to comply with this policy and to ensure members of their teams are aware of this duty.

6.5 All employees must:

6.5.1 comply with the "Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England".

6.5.2 understand their duty for "being open";

6.5.3 demonstrate the principles of being open in their work;

6.5.4 when made aware of an incident or near miss having occurred must follow Expect's Incident Reporting Policy HS006 and apply the principles of being open and the Duty of Candour throughout these processes;

6.5.5 when dealing with Service Users or relatives, abide by Expect's complaints process MA002 and advise who Service Users or carers should write to if they wish to formalise a complaint;

6.5.6 if concerned about the non-reporting or concealment of incidents, or about on-going practices which present a serious risk to Service User safety, staff must raise their concerns through established governance routes i.e: whistleblowing policy.

## 7 DUTY OF CANDOUR

7.1 The statutory Duty of Candour only applies to incidents where a Service User suffered (or could have suffered) unintended harm resulting in moderate or severe harm or death or prolonged psychological harm.

7.2 The requirements of the Duty of Candour as set out by the regulations are as follows.

7.2.1 As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body (Expect) must:

(a) notify the relevant person that the incident has occurred;
(b) provide reasonable support to the relevant person in relation to the incident, including when giving such notification.

7.2.2 The notification must:

(a) be given in person by one or more representatives of the health service body (Expect);

(b) provide an account, which to the best of the health service body's knowledge is true, of all the facts the health service body knows about the incident as at the date of the notification;
(c) advise the relevant person what further enquiries into the incident the health service body believes are appropriate;
(d) include an apology, and;
(e) be recorded in a written record which is forwarded to the Head of Quality..

7.2.3 This notification must be followed up in writing.

7.3 Incidents that result in no harm or low harm are not covered by the Duty of Candour. Service Users should still be informed of such events in line with being open, but the emphasis for the Duty of Candour is on incidents that result in moderate harm, severe harm or death.

7.4 There will be exceptions to implementing the Duty of Candour and where this is the case, there must be very sound reasons, which must be clearly recorded, for not having the Duty of Candour principles applied.

## 8 LEVEL OF HARM

8.1 The regulations state that the Duty of Candour applies to incidents as follows:
(a) the death of the Service User, where the death relates directly to the incident rather than to the natural course of the 's illness or underlying condition, or
(b) severe harm, moderate harm or prolonged psychological harm to the; "prolonged psychological harm" means psychological harm which a has experienced, or is likely to experience, for a continuous period of at least 28 days;

8.2 Moderate harm" means—
(a) harm that requires a moderate treatment, and
(b) significant, but not permanent, harm;

8.3 **Moderate treatment** could involve surgery, an unplanned admission to

hospital, time in hospital as an outpatient or transfer to another service for care. More detail about levels of harm can be found in Appendix 1.

## 9 SHARING OF INFORMATION WITH RELEVANT PEOPLE

9.1 Service Users 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, while others will not want to know. There will always be an element of professional judgement in determining what information should be given. 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.

## 10 CHILDREN AND YOUNG PEOPLE

10.1 Young people are owed the same duties of care and confidentiality as adults. Confidentiality may only be broken when the health, safety or welfare of the young person, or others, would otherwise be at grave risk.

10.2 Where a child or young person is judged to have the mental capacity and the emotional maturity to understand the information provided (refer to the Fraser guidelines http://www.fpa.org.uk/factsheets/under-16s-consent-confidentiality) then he/she should be involved directly in the Duty of Candour process following a notifiable Service User safety incident.

10.3 Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents alone or in the presence of the child. In these instances the parents' or legal guardian's views on the issue should be sought.

## 11 BEING OPEN AND DUTY OF CANDOUR PROCESSES

11.1 Some managers will find themselves in the difficult position of having to discuss harm or potential harm with a Service User at some time in their career. The following guidance provides a framework for staff and their managers to work to.

11.2 A summary of the stages involved in this process is provided in Appendix 4 together with a flow chart in Appendix 8. It should be noted that if the incident/event constitutes one regulatory notification to the local authority/Police, Expect's safeguarding Policy/Procedure should not be commenced until relevant advice and guidance is received alongside permission to proceed.

## 12 INCIDENT IDENTIFICATION AND REPORTING

12.1 Firstly any actions that can be taken immediately to reduce the risk of harm to the Service User must be implemented.

12.2 The incident must be reported via Expect's Incident Reporting Policy. HS006.

## 13 STAGE ONE: INITIAL FACT FINDING

13.1 The initial facts of the incident should be established and an assessment of the level of harm that has happened to the Service User as a result of the incident should be undertaken by a either Expect's Head of Operations or their assistant.

13.2 All incidents must be reported through Expect's Incident Reporting Policy. The incident report must be completed as soon as possible after the incident has been discovered, and always within 48 hours of detecting the incident.

## 14 STAGE TWO: BEING OPEN

14.1 **Being Open:** There are a set of principles for being open (Appendix 2) that

staff should refer to when communicating with the relevant person following an incident in which the Service User/ was harmed.

14.2 **Mental Capacity:** Where the Service User or Service User is assessed as not having the capacity to make a decision in relation to their care or treatment, or where the Service User/ is under 16 and deemed not to have the necessary competency, then the most appropriate relevant person should be notified of the incident.

14.3 **Confidentiality:** Details of a Service User's care and treatment should at all times be considered confidential. Where the Duty of Candour would include providing confidential information to family or carers, then the consent of the individual concerned should be sought prior to disclosing information. This consent or denial of consent to share should be recorded in the Service User's notes and subsequent investigation documentation.

14.4 The Relevant Person Cannot be Contacted or Declines to Have Further Information:

- If, after discussion, the Service User says they do not want more information, then the possible consequences must be explained to them. It should be made clear that they can change their mind and have more information at any time.
- All Duty of Candour conversations must be recorded in the case notes including instances when the Service User has declined the offer of further information.
- Where a relevant person cannot be contacted, a clear written record must be kept of the attempts made to contact or speak to the relevant person. This should evidence that every reasonable effort was made to contact the person by stating how many attempts were made, who by and when.

## 15 STAGE THREE: APOLOGY

15.1 The initial 'being open' communications will vary according to the individual needs of the relevant person, the severity grading of the incident and family circumstances for each specific event. The Head of Operations should coordinate this initial communication, ensuring that the relevant person

receives clear, unambiguous explanation of the event and the next steps to be taken. It is also vital that staff involved in the incident receive appropriate support from the outset.

15.2 Where a Service User safety incident has caused harm, an apology must be offered to the relevant person – a sincere expression of sorrow or regret for any possible harm and distress caused.

15.3 Clarity of Communication: The individual communication needs of the relevant person, for example, linguistic or cultural needs, learning disabilities, or sensory impairments must be considered and taken into full account before any discussion takes place.

15.4 The relevant person must be fully informed of the issues surrounding the Service User safety incident and its consequences in a face to face meeting.

15.5 The facts that are known should be explained. When talking to the relevant person about the incident, staff must use clear straightforward language and be honest with responses to any questions that are raised.

15.6 The relevant person should be informed that an incident analysis will be carried out by the Head of Operations and more information will become available as this progresses.

15.7 It should be made clear to the relevant person that new facts may emerge as the incident analysis proceeds.

15.8 The relevant person's understanding of what happened should be established from the outset, as well as any questions they may have.

15.9 There should be consideration and formal noting of the relevant person's views and concerns, and demonstration that these have been heard and taken seriously.

15.10 An explanation should be given about what will happen next in terms of the long term support and care for the Service User as well as the incident analysis findings.

15.11 Information on likely short and long-term effects of the incident (if known) should be shared.

15.12 An offer of practical and emotional support should be made to the relevant person.

15.13 Service Users, family and/or carers might be anxious, angry and frustrated, even when the discussion is conducted appropriately. It is essential that staff are not drawn into speculation, attribution of blame, denial of responsibility or the provision of conflicting information.

## 16 STAGE FOUR: THE INVESTIGATION

16.1 **Investigating Officer:** The Head of Operations will appoint one of Expects Managers as Investigating Officer (IO). The Investigating Officer should be the point of contact throughout an investigation between the Service User, the family and Expect. This communication role can be undertaken by another person such as a senior manager if this is more appropriate, but whoever the contact is must be recorded in the Service Users notes and the RCA documentation.

16.2 For Serious Incidents, the IO will meet with the employee(s) directly involved in the incident to establish the facts.

16.3 Where an incident is identified as a safeguarding concern, Expect's safeguarding process shall be followed.

16.4 The actions above should be followed by a letter to the Service User/relatives with an offer of a meeting, if this is appropriate. This should be written by the most appropriate person. This may be before the conclusion of the investigation. An example template letter is provided in Appendix 5.

16.5 The letter should advise the Service User of an independent advocacy service available to support and assist them.

16.6 The IO will keep the person who is overseeing the Duty of Candour process up to date on progress with the investigation.

## 17 STAGE FIVE: COMMUNICATION

17.1 Communication with the Relevant Person: A meeting with the relevant person should be arranged as soon as possible after the incident has happened to notify them of the incident. This meeting should always take place within 10 working days of the incident being discovered.

17.2 It may be appropriate for more than one member of staff to meet with the relevant person for support or for additional information.

17.3 At the meeting the nominated member of staff should follow the procedure below:

I. If known, explain what went wrong and where possible, why it went wrong;

II. Inform the Service User and/or relative(s) and others what steps are being/will be taken to prevent the incident recurring;

III. Offer an apology;

IV. Provide opportunity for the Service User and/or relatives and others to ask any questions;

V. Agree with the Service User and/or relatives and others any future meetings as appropriate;

VI. Suggest any sources of additional support and counselling and provide written information if appropriate;

VII. Inform the relevant person that they will receive a written summary of the incident and that they will be, if they wish, be informed of progress with the investigation. The relevant person will also receive a copy of the final investigation report.

17.4 Wherever possible a named contact should be provided who the relevant person can speak to regarding the incident.

17.5 A letter should then be written to the relevant person setting out what was explained at the notification meeting immediately after the notification meeting and approved by the Head of Operations/Care Manager prior to sending out. The letter must contain all the information that was provided at the initial notification meeting, including:

(a) the information provided;

(b) details of any enquiries to be undertaken;

(c) the results of any further enquiries into the incident; and,

(d) an apology.

17.6 Any Duty of Candour letters arising out of the notification meeting must be signed off by the Head of Operations/Care Manager and a copy kept in the case notes.

17.7 If, for whatever reason, the Service User cannot be contacted in person or declines to speak to anyone from Expect in relation to the incident, then the above processes do not apply but a written record must be kept of the attempts made to contact or to speak to the relevant person.

## 18 STAGE SIX: INVESTIGATION CLOSURE AND LEARNING

18.1 The full investigation report will be presented at the senior managers meeting. This will include details of how the Duty of Candour has been implemented.

18.2 Once the incident is signed off for closure by the senior managers, a letter should be sent to the relevant person together with the anonymised investigation report and action plan. The supporting letter should provide information in the event that the individual wishes to pursue legal action against Expect. This letter will be signed off by the Chief Executive or their nominated deputy.

18.3 If the investigation is not available within the usual time frame for closure, a letter should be sent to the relevant person to provide an explanation as to when they can expect to be provided with additional details. This letter should clarify the information previously provided, reiterate key points, and record action points and future deadlines.

18.4 The senior managers will ensure all learning from the incidents is used to improve service delivery.

18.5 The outcome of reports will be shared with relevant stakeholder as appropriate to optimise learning from the incident.

## 19 DOCUMENTATION

19.1 With specific relation to the Being Open/Duty of Candour records 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 Service User and their family/carers;
- 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;
- Record an offer of appropriate practical and emotional support.

## 20 PERFORMANCE/DISCIPLINARY ISSUES

20.1 All actions resulting from incidents requiring disciplinary action will be dealt with under Expect's disciplinary procedure, HR011.

## 21 APPENDIX 1: LEVELS OF HARM

| Incident | Action |
|---|---|
| **No harm**<br>*(including prevented Service User safety incidents)* | o Service Users are not usually contacted or involved in investigations and these types of incidents are **outside** the scope of the *Duty of Candour*. Openness remains best practice, but there is no requirement to follow the Duty of Candour processes. |
| **Low harm** | o Unless there are specific indications or the Service User requests it, the communication, investigation and analysis, and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the incident.<br>o Communication should take the form of an open discussion between the staff providing the Service User's care and the Service User and/or their carers.<br>o Reporting to the operational managers will occur through standard incident reporting and will be analysed centrally to detect high frequency events.<br>o Review will occur through aggregated trend data and local investigation.<br>Where the trend data indicates a pattern of related events, further investigation and analysis may be needed.<br>Openness remains best practice, but there is no requirement to follow the Duty of Candour processes for incidents that result in this level of harm. . |
| **Moderate harm**<br><br>**Severe harm or death** | o The *Duty of Candour* policy is implemented.<br>o It will be necessary to inform the Head of Operations. For Never Events senior manager must be informed immediately and for the most serious incidents, the Service User Safety Team will also need to be contacted as quickly as possible to ensure everyone who needs to know is informed. Expect operates within openness principles with our commissioners and regulators, and we will inform these organisations of the incident and the management plans as soon as possible/as required. |

## 22 APPENDIX 2: THE PRINCIPLES OF BEING OPEN

**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 Service User and their family informed as part of any subsequent review.

22.1 **Principle of Acknowledgement**: All Service User safety events should be acknowledged and reported as soon as they are identified. In cases where the Service User, their family and 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.

22.2 **Principles of Truthfulness, Timeliness and Clarity of Communication:** Information about a Service User safety incident must be given in a truthful and open manner by an appropriately nominated person. Communication should be timely, informing the Service User, 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. Service Users, 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.

22.3 **Principle of an Apology:** Service Users, 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 Service User 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 Service User safety event, should also be given.

22.4 **Principle of Recognising Service User and Carer Expectations:** Service Users, their families and carers can reasonably expect to be fully informed of

the issues surrounding a Service User safety incident, and its consequences, in a face to face meeting with representatives from the organisation and/or in accordance with the local resolution process where a complaint is at issue. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times. Service Users, 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.

22.5 **Principle of Professional Support:** Expect has set out to create an environment in which all employees are encouraged to report Service User safety events. Employees should feel supported throughout the Service User safety event investigation process; they too may have been traumatised by the event. Resources available are referred to within the respective policies, to ensure a robust and consistent approach to Service User safety event investigation. Where there are concerns about the practice of individual employee Expect's Human Resources department must be contacted for advice. Where there is reason to believe an employee has committed a punitive or criminal act, Expect 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.

22.6 **Principle of Risk Management and Systems Improvement**: Root Cause Analysis (RCA) or similar techniques should be used to uncover the underlying causes of Service User 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 Service User safety incident reporting and risk management policies and processes.

22.7 **Principles of Multi-Disciplinary Responsibility:** *Being open* applies to all employees who have key roles in Service User care. This ensures that the *Being open* process is consistent with the philosophy that Service User

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 Service User safety incident investigation and clinical risk management as set out in Expect's respective policies and practice guidance.

22.8 **Principles of Clinical Governance**: Being open involves the support of Service User safety and quality improvement through Expect's clinical governance framework, in which Service User 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 Service User safety incidents. Audits are an integral process, to monitor the implementation and effects of changes in practice following a Service User safety incident.

22.9 **Principle of Confidentiality:** Details of a Service User's safety incidents 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 Service User. Expect 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 Service User 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 Service User, 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. Consent and duty to inform for incidents involving Service Users in Offender Health will be dealt with in accordance with the normal prison protocol.

22.10 Principle of Continuity of Care: Service Users will continue to receive all

usual support and care and continue to be treated with respect and compassion.

## 23 APPENDIX 3: SUPPORT AND ADVICE FOR STAFF

23.1 **Support and Advice for Staff:** It is very rare for staff go to work with the intention of causing harm or failing to do the right thing. While we do all we can to minimise risks, it will never be possible to eliminate them fully. It should be acknowledged from the outset that many 'human factors' can increase the risk of incidents occurring such as:

- Workload;
- Distractions;
- Physical environment;
- Physical demands;
- Device/product design.

23.2 It is uncommon for any single action or 'failure' to be wholly responsible. The focus following an incident should always be on learning and prevention rather than individual blame.

23.3 Involvement in an incident and particularly a serious incident can have profound consequences on staff members who may experience a range of reactions. The high personal and professional standards of most other staff may make them particularly vulnerable to these experiences. Different individuals will have differing responses to the same incident and support should always therefore be tailored to the individual. The Human Resources Department and operational management is able to advise on resources available in Expect, but the support of close team members and line managers is invaluable for the staff involved, and for taking forward learning from the event.

- The initial level of support is provided by line managers for employees involved in a Service User safety incident.
- The second level of support is provided by appropriate Senior Managers. Further escalation may be required depending on the severity of the incident.
- A further level of support is provided by the Executive Directors who participate in the 24 hour on call rotas.

## 24 APPENDIX 4:- BRIEF SUMMARY OF THE STAGES IN THE DUTY OF CANDOUR PROCESS

| Requirement under Duty of Candour | Responsible Person/Department | Timeframe |
|---|---|---|
| For incidents where moderate harm, serious harm or death has occurred, the relevant person must be informed. | The Operational Manager should be made aware and if appropriate, involved. | As soon as possible after the incident has been detected and reported but always within 10 working days of the incident |
| Initial notification of incident must be verbal (face-to-face, where possible) unless the relevant person declines notification or cannot be contacted in person. Sincere expression of regret or sorrow must be provided verbally. This must be recorded in the notes. | The Operational Manager should be made aware and if appropriate, involved, and agree who shall make contact with the relevant person. | As above. |
| Step-by-step explanation of the known facts must be offered to the relevant person, by the identified Expect manager. | As above | As above |
| Written notification to the relevant person. The written notification should outline the facts discussed at the notification meeting and include a sincere expression of regret or sorrow. | As above. All letters must be approved by the operational manager/CEO. | As above |
| Maintain full written documentation of any meetings. If meetings are offered but declined this must be recorded | As above. | |
| Share incident investigation report (including action plans) with an accompanying letter. | Investigating Officer or other nominated person. Letter to be approved by Head of Operations/CEO. | As soon as reasonably practicable but always within 25 working days of report being signed off as complete and incident closed. |

## 25 APPENDIX 5: INITIAL COMMUNICATION LETTER

**Guidance letter template for initial communication letter in accordance with requirements of Duty of Candour.**

**NB This is provided purely for guidance. All letters must be personalised and tailored to the individual needs of the person receiving the letter.**

Dear Mrs/Mrs xxxxxxxxxxx

I am writing to express my sincere regret that (you/your relative XXXXX) has been involved in an incident whereby …….(describe event here). At Expect we are committed to being open with Service Users and relatives when events such as these occur so that we gain a shared understanding of what happened, and what we can do to prevent such an incident occurring again in the future.

An investigation is already underway to try and establish the cause of the incident. If you would like to meet with a member of staff to discuss this, please let me know within the next two weeks, and we will arrange a mutually convenient time and place to meet.

There is an independent advocacy service available to support and assist you in this who can be contacted on XXXXXXX.

Staff member XXXXX is acting as your lead contact for the duration of the investigation. They can be contacted by email on xxxxxxxxxxxxxxx or on telephone number xxxxx xxxxxxx

Yours sincerely

## 26 APPENDIX 6: DUTY OF CANDOUR FLOWCHART