Being Open and Duty of Candour Policy

State whether the document is: ☑ **Trust wide** ☐ Business Group ☐ Local	**State Document Type:** ☑ **Policy** ☐☐Standard Operating Procedure ☐ Guideline ☐ Protocol
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RELATED APPROVED TRUST DOCUMENTS	Being Open and Duty of Candour SOP Incident Reporting and Management Policy Procedure for investigation of incidents complaints and claims Procedure for reporting and learning from serious incidents Complaints Policy
AUTHOR/FURTHER INFORMATION	Risk and Safety Assurance Manager Head of Risk and Customer Services
THIS DOCUMENT REPLACES	Being Open Policy Version 3

Document Change History:

Issue No	Page	Changes made (include rationale and impact on practice)	Date
Version 1	all	Complete re write following issue of NPSA guidance	June 2010
Version 2 - Rev 1	Monitoring table	Change to monitoring table only in line with NHSLA requirements	Nov 2011
Version 3	all	New reporting structures	October 2012
Version 4	all	New CQC Regulation 20	December 2014

1.0 INTRODUCTION

Stockport NHS Foundation Trust is committed to the provision of high quality health care. As part of this objective, promoting a culture of openness and truthfulness is a prerequisite to improving the safety of patients, staff and visitors as well as the quality of healthcare systems. This culture ensures communication is open, honest and occurs as soon as possible following a patient safety event or when a poor outcome has been experienced. It encompasses the communication between healthcare organisations, healthcare teams and patients, their families and carers.

An apology is not an admission of liability and is the right thing to do. Openness and honesty towards patients are supported and actively encouraged by many professional bodies including the Medical Defence Union (MDU), the Medical Protection Society (MPS), the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC).

1.1 In September 2005 the National Patient Safety Agency (NPSA) issued a Safer Practice Notice advising all NHS organisations to implement a Being Open Policy. In November 2009 a Patient Safety Alert was issued by the NPSA to ensure that providers of NHS funded care implemented the principles of Being Open. In addition, the Francis Report (2013) makes recommendations with regard to Openness, Transparency and Candour

Since 1 April 2013 it is a requirement under the NHS Standard Contract 2013/14, issued by the NHS Commissioning Board to ensure that 'patients or their Next of Kin, if the patient has consented to you informing them or does not have capacity, are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and are supported to deal with the consequences' (2012-14 NHS Standard Contract, Technical guidance)

The Health and Social Care Act 2008 Regulation 20: Duty of Candour; (introduced from 27 November 2014) states that: "the Trust must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity". As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a Trust must—

1. Notify the relevant person that the incident has occurred and provide reasonable support to the relevant person in relation to the incident, including when giving such notification.
2. The notification must be given in person by one or more representatives of the Trust
3. Provide an account, which to the best of the Trust knowledge is true, of all the facts the Trust knows about the incident as at the date of the notification,
4. Advise the relevant person what further enquiries into the incident the Trust believes are appropriate,
5. Include an apology, and be recorded in a written record which is kept securely by the Trust.
6. The notification must be followed by a written notification given or sent to the relevant person containing—
    - an account, which to the best of the Trust knowledge is true, of all the facts the Trust knows about the incident as at the date of the notification,
    - details of any enquiries to be undertaken
    - the results of any further enquiries into the incident, and
    - An apology.
    - But if the relevant person cannot be contacted in person or declines to speak to the representative of the Trust the above do not apply, however a written record is to be kept of attempts to contact or to speak to the relevant person.
7. Keep a copy of all correspondence with the relevant person

1.2 The Being open elements of this policy are based on guidance from the National Patient Safety Agency (NPSA), 'Seven Steps to Patient Safety, Involve and Communicate with Patients and the public' and the National Health Service Litigation Authority (NHSLA) communication of May 2009 "Apologies and explanations". The seven steps encourage healthcare staff to apologise to patients who are harmed as a result of healthcare treatment and explain that an apology is not an admission of liability. Duty of candour elements are based on the NHS Commissioning Standards

201/15 and the Health and Social Care Act 2008 Regulation 20alth and Social Care Act 2008 Regulation 20

This Policy document should be read in conjunction with the Trust Standard Operating Procedure for Being Open and Duty of Candour, which can be accessed via the Duty of Candour Intranet Site

2.0 PURPOSE

The purpose of this document is to ensure that patients, their families and carers, and staff all feel supported when patient safety events occur/things go wrong. This document also aims to improve the quality and consistency of communication with patients, their families and carers when patient safety events occur, so that they receive promptly the information they need to enable them to understand what happened; that a meaningful apology is offered; and they are informed of the action the organisation will take to try and ensure that a similar type of patient safety event does not recur.

This document aims to provide clear information to staff on what they do when they are involved and the support available to them to cope with the consequences of what happened and to communicate with patients, their families and carers effectively.

3.0 DEFINITIONS

NB: Being Open and Duty of Candour applies principally to incidents but they may lead to secondary complaints and claims that should be treated in the same way. The term patient safety event is used in this policy to cover patient safety incidents, complaints and claims**.**

3.1 **"Being open"** refer to the process for communicating adverse events with patients and their carers, staff and visitors.

3.2 **Candour**: Any patient harmed by the provision of healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked. (Francis 2013)

3.3. "**Apology**":- An expression of sorrow or regret in respect of a notifiable safety incident.

3.4 "**Notifiable safety incident**":- Any unintended or unexpected incident that occurred in respect of a service user during the provision of a of a regulated activity that, in the reasonable opinion of a healthcare professional, could result in or appears to have resulted in —

a. the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or
b. severe harm, moderate harm or prolonged psychological harm to the service user;

3.5 "**Prolonged psychological":-** Psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;

3.6 **Moderate harm means**

a. Harm that requires a moderate increase in treatment, and
b. Significant, but not permanent harm;

"moderate increase in treatment" means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care);

NB: "Moderate harm" is classified as "Major incidents"

3.7 **Severe harm**: - A permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related

directly to the incident and not related to the natural course of the service user's illness or underlying condition

3.8 **Relevant person**:- The service user or, in the following circumstances, a person lawfully acting on their behalf—(a) on the death of the service user, (b) where the service user is under 16 and not competent to make a decision in relation to their care or treatment, or (c) where the service user is 16 or over and lacks capacity

3.9 **Incident: -** An event or circumstance arising that could have or did lead to harm, loss or damage, to staff, patient, visitors, public or Trust property

3.9 **Complaint:-** This can refer to; both informal and formal complaints, made by the patient, their relatives, carers, or a person nominated by the patient to represent them.

3.10 **Reasonable amount of time:** A reasonable amount of time is not defined in the regulation. However, the NHS Standard Contract requires that the notification must be within at most 10 working days of the incident being reported to local systems, and sooner where possible..

4.0 ROLES AND RESPONSIBILITIES

The *Being Open* policy is aimed at all healthcare staff responsible for patient care and for ensuring that the infrastructure is in place to support openness between healthcare professionals and patients, their families and carers following a patient safety event.

Trust Board

The designated member of the Trust Board who will take responsibility for the *Being Open Policy is* the **Director of Nursing and Midwifery** who will endeavour to be fully informed and assured that the principles are working and are being adhered to and will ensure that results of the monitoring of the "being Open Policy" are presented to the Trust Board.

Chief Executive

The Chief Executive Officer of Stockport NHS Foundation Trust is responsible for the process of managing and responding to the "*Being open"* process and for ensuring that this responsibility is delegated to appropriate personnel.

Executive Directors

Executive Directors are responsible for promoting an open, honest and fair culture within the organisation.

Associate Directors

Associate Directors are responsible for ensuring that there are identified persons within the business group who will take responsibility for adherence to policy; and for ensuring that monitoring of the policy, as required by this document is completed with any required actions plans being developed, actioned and monitored.

Chair of Serious Untoward Incident Meetings

Will ensure that the Being Open policy is adhered to when conducting a serious untoward incident meeting and ensure that all actions are taken in a timely manner.

Head of Risk and Customer Services

The Head of Risk and Customer Services will ensure that the principles outlined in the policy document are adhered to in management of all patient safety events.

They will compile an annual report of adherence to the "Being Open Policy" with information collected from the business groups. This report will be presented to the Risk Management committee and Quality Governance Committee along with an Action Plan developed by any business group where findings are that the policy is not being complied with. This Action Plan will be shared with the Governance and Risk Leads who will feed back to the business group quality board.

Governance/Risk Leads within Business Groups

Will ensure that "Being Open" is considered for all patient safety incidents and that the standard operating procedure for "being open" is adhered to.

They will be responsible for performing an audit of the "being open" procedure for patient safety incidents within their business group annually and feed this information back to the Risk and Customer Services Manager for aggregation with all business groups.

They will receive the Annual Report on adherence to the Being Open policy from the Head of Risk and customer services and present it along with an agreed action plan (developed within the business group) to the Quality Board.

Heads of Nursing/Clinical Directors/Matrons

All Heads of Nursing, Clinical Directors and Matrons will ensure that they are role models in the principles of being open, that they ensure all policies and procedures are followed with respect to *Being open* and that they:

- Attend where applicable meetings with patients involved in a patient safety event/ and/or their carer(s)
- Where relevant providing the patient, their family and carers with verbal and written apology
- Ensure that the patient has been provided with a contact name in the event of further queries or issues arising
- Arranging for transfer of care where the patient, their family and carer(s) request this
- Documenting the details of all discussion with the patient and/or their carer(s)
- Keeping in close communication with the event investigation leads to enable regular and informed communication with the patient, their family and carers
- Ensure that staff are at all times supported through the process of being open and are offered access to appropriate support/counselling via Occupational Health as required.

All Staff

All staff working within the Trust will be expected to adhere to this policy and promote an open, honest and fair culture within the organisation. All staff have a responsibility for making sure that incidents or complaints are acknowledged and reported as soon as they are identified. In cases where the patient and/or carers inform healthcare staff when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all healthcare staff.

Quality Governance Committee

This meeting will receive the Annual Report regarding adherence to the policy and agree an Action Plan to address any shortfalls in meeting the requirements.

The Policy is available to all staff and relevant stakeholders via the intranet on the Patient and customer service Microsite.

5.0 PRINCIPLES

This policy reflects the 'Ten Principles of "Being open" as identified in the National Patient Safety Agency's document "Being open": communicating patient safety incidents with patients and their carers' (NPSA, 2005). The following principles will underpin our practice:

5.1 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 carers inform healthcare staff that something has happened, their concerns must be taken seriously and should be treated with compassion and understanding by all staff. Denial of a person's concerns will make future open and honest communication more difficult.

5.2 Principle of Truthfulness, Timeliness and Clarity of Communication

Information about a patient safety event must be given in a truthful and open manner by an appropriately nominated person. Communication should also 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. Explain that new information may emerge as the patient safety event investigation takes place and that they will be kept up to date. Patients, their families and carers should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have.

5.3 Principle of 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. This should be in the form of an appropriately worded agreed manner of apology, as early as possible. Both verbal and written apologies should be given. 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. A written apology, which clearly states the organisation is sorry for the suffering and distress resulting from the patient safety event, must also be given.

5.4 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 event, and its consequences, in a face to face meeting with representatives from the organisation. 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 on the Patient and Customer Services team and other relevant support groups should be given as soon as possible.

5.5 Principle of Professional Support

The organisation will create an environment in which all staff are encouraged to report patient safety events. Staff should feel supported throughout the patient safety event investigation process; they too may have been traumatised by the patient safety event.

Using Root Cause Analysis Tools can help to ensure a robust and consistent approach to patient safety event investigation. Where there are concerns about the performance of individual doctors, dentists of pharmacists the National Clinical Assessment Service (NCAS) can be contacted for advice. Where there is reason for the healthcare organisation to believe a member of staff has committed a punitive or criminal act, the organisation should take steps to preserve its position and advise the member(s) of staff at an early stage to enable them to obtain separate legal advice and/or representation. Staff should be encouraged to seek support from relevant professional bodies.

5.6 Principle of Risk Management and Systems Improvement

A Root Cause Analysis (RCA), should be used to uncover the underlying causes of patient safety events. This investigation should focus on improving systems of care, which will be reviewed for their effectiveness. This *Being open* document will be integrated into the Trust Risk Management Policy, the Procedure for Investigating Incidents Complaints and Claims, the Incident Reporting Policy, The Inquest Policy and the Serious Untoward Incident Policy.

5.7 Principle of Multi-Disciplinary Responsibility

The *Being open* policy applies to all staff who have key roles in patient care. Most healthcare provision involves multi-disciplinary teams. This should be reflected in the way that patients, their families and carers are communicated with when things go wrong. This will ensure that the *Being open* process is consistent with the philosophy that patient safety events 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, nursing and managerial leaders who will support it. Both senior managers and senior clinicians must participate in the patient safety event investigation and clinical risk management.

5.8 Principle of Clinical Governance

Being open requires the support of patient safety and quality improvement through clinical governance frameworks, in which patient safety events are investigated and analysed, to find out what can be done to prevent their recurrence. It also involves a system of accountability through the chief executive to the board to ensure that these changes are implemented and their effectiveness reviewed. These findings should be disseminated to staff so they can learn from patient safety events. Audits should be developed to monitor the implementation and effects of changes in practice following a patient safety event.

5.9 Principle of Confidentiality

Details of a patient safety event 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. Where this is not practicable or an individual refuses consent to the 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 the clinical team should also be on a strictly need to know basis and, where practicable, records should be anonymous. 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.

5.10 Principle of Continuity of Care

Patients are entitled to expect they will continue to receive all usual treatment and continue to be treated with respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made for them to receive treatment elsewhere.

6.0 PATIENT REQUIREMENTS AND NEEDS TO CONSIDER

The approach to *Being open* may need to be modified according to the patients' personal circumstances. The following gives guidance on what may need to be considered for different categories of patient circumstances.

6.1 Communication

For open and effective communication around patient safety incidents the Trust will:

- Ensure early identification of, and consent for the patient's practical and emotional needs. This includes:
  a. The names of people who can provide assistance and support to the patient, and to whom the patient has agreed that information about their healthcare can be given
  b. Any special restrictions on openness that the patient would like the healthcare team to respect
  c. Identifying whether the patient does not wish to know every aspect of what went wrong: respect their wishes and reassure them that this information will be made available to them later on if they change their mind
- Provide repeated opportunities for the patient their family and carers to obtain information about the patient safety incident.
- Provide information to patients in written and verbal formats.
- Provide ongoing assurance that an ongoing care plan will be developed in consultation with the patient and will be followed through
- Provide assurance that the patient will continue to be treated according to their clinical needs and that the prospect of, or an actual dispute between the patient, their family and carers and the healthcare team will not affect their access to treatment.
- Facilitate inclusion of the patient's family and carers in discussions about a patient safety incident if the patient agrees.
- Provide the patient's family and carers with access to information to assist in making decisions if the patient is unable to participate in decision making or if the patient has died as a result of an incident. This should be done with regard to confidentiality and in accordance with the patient's instructions.

- Determine whether you will need to repeat this information to the patient at different times to allow them to comprehend the situation fully.
- Ensure that the patient's family and carers are provided with known information, care and support if a patient has died as a result of a patient safety incident. The carers should also be referred to the coroner for more detailed information.
- Ensure that discussions with the patient, their family and carers are documented and that information is shared with them.
- Ensure that the patient, their family and carers are provided with information on the complaints procedure if they wish to have it.
- Ensure that the patient, their family and carers are provided with information on the incident reporting process.
- Ensure that the patient's account of the events leading up to the patient safety incident is fed into the incident investigation, whenever applicable.
- Ensure that the patient, their family and carers are provided with information on how improvement plans derived from investigations will be implemented and their effects monitored.
- Develop a system for monitoring and auditing the patient's, their family's and carers' perceptions of the *Being open* process and ensure their comments are fed back to healthcare staff.

6.2 Advocacy and Support

Patients, their families and carers may need considerable practical and emotional help and support after experiencing a patient safety incident. The most appropriate type of support may vary among different patients, their families and carers. It is therefore important to discuss with the patient, their families and carers their individual needs. Support may be provided by patients' families, social workers, religious representatives and healthcare organisations such as Independent Complaints Advocacy Service (ICAS) and CHCs in Wales. Where the patient needs more detailed long-term emotional support, advice should be provided on how to gain access to appropriate counselling and support services, for example, from Cruse Bereavement Care and AvMA.

Healthcare organisations should provide:

- Information on services offered by all the possible support agencies (including their contact details) that can give emotional support, help the patient identify the issues of concern, support them at meetings with staff and provide information about appropriate community services.
- Contact details of a staff member who will maintain an ongoing relationship with the patient, using the most appropriate method of communication from the patient's, their family's and carers' perspective. Their role is to provide both practical and emotional support in a timely manner.
- Information on the *Being open* process in the form of a short leaflet explaining what to expect.
- Information on how to make a formal complaint and/or any other available means of giving positive or negative feedback to healthcare staff involved in their care.

6.3 When a patient dies

In these cases it is essential that communication is sensitive, empathic and open. It is important to consider the emotional state of the bereaved relatives or carers and involve them in deciding when it is appropriate to discuss what has happened.

Usually the Being open discussion and investigation will occur before a coroner inquest, but in certain circumstances the healthcare organisation may consider it appropriate to wait for the coroners inquest before holding the being open discussion with the family/carer.

The coroner's post mortem is a key source of information that will help to complete the picture of events leading up the patient's death. In any event an apology should be issued as soon as possible after the patient's death, together with an explanation that the coroners process has been initiated and a realistic timeframe of when the family and carers will be provided with more information.

6.4 Particular patient circumstances

The Being Open Process should at all times take account of the varying needs all patients in respect to background, religion, language, belief and disability**.**

Children

The legal age of maturity for giving consent to treatment is 16 years old. It is the age at which a young person acquires the full rights to make decisions about their own treatment and their right to confidentiality becomes vested in them rather than their parents or guardians. However, it is still considered good practice to encourage competent children to involve their families in decision making.

The courts have stated that younger children who understand fully what is involved in the proposed procedure can also give consent. This is sometimes known as Gillick competence (please refer to the Consent Policy for more information). Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the *Being open* process after a patient safety incident. The opportunity for parents to be involved should still be provided unless the child expresses a wish for them not to be present. 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' views on the issue should be sought.

Patients with Mental Health Issues

Being open for patients with mental health issues should follow normal procedures, unless the patient also has cognitive impairment (see 'Patients with cognitive impairments'). The only circumstances in which it is appropriate to withhold patient safety incident information from a patient with mental health issues, is when advised to do so by a consultant psychiatrist who feels it would cause adverse psychological harm to the patient. However, such circumstances are rare and a second opinion (by another consultant psychiatrist) would be needed to justify withholding information from the patient. Apart from in exceptional circumstances, it is never appropriate to discuss patient safety incident information with a carer or relative without the express permission of the patient.

Patients with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them. They may have authorised a person to act on their behalf by an enduring Power of Attorney. In these cases, steps must be taken to ensure that this extends to decision making and to the medical care and treatment of the patient.

The *Being open* discussion would be conducted with the holder of the power of attorney. Where there is no such person, the clinicians may act in the patient's best interest in deciding who the appropriate person is to discuss incident information with, regarding the welfare of the patient as a whole and not simply their medical interests. However, the patient with a cognitive impairment should, where possible, be involved directly in communications about what has happened. An advocate with appropriate skills should be available to the patient to assist in the communication process. See 'Patients with learning disabilities' for details of appropriate advocates.

Information regarding Mental Capacity and Mental Capacity Advocates can be found on the Trust Intranet under Mental Capacity all guidelines and assessment tools are available here.

Patients with Learning disabilities

Where a patient has difficulties in expressing their opinion verbally, an assessment should be made about whether they are also cognitively impaired (see 'Patients with cognitive impairment'). If the patient is not cognitively impaired they should be supported in the *Being open* process by alternative communication methods (e.g. given the opportunity to write

questions down). An advocate, agreed on in consultation with the patient, should be appointed. Appropriate advocates may include carers, family or friends of the patient. The advocate should assist the patient during the *Being open* process, focusing on ensuring that the patient's views are considered and discussed.

Patients with different language or cultural considerations

The need for translation and advocacy services, and consideration of special cultural needs (such as for patients from cultures that make it difficult for a woman to talk to a male about intimate issues), must be taken into account when planning to discuss patient safety incident information. It would be worthwhile to obtain advice from an advocate or translator before the meeting on the most sensitive way to discuss the information. Avoid using 'unofficial translators' and/or the patient's family or friends as they may distort information by editing what is communicated. Please refer to the translation policy for more information regarding translators.

Patients with different communication needs

A number of patients will have particular communication difficulties, such as a hearing impairment. Plans for the meeting should fully consider these needs. Knowing how to enable or enhance communications with a patient is essential to facilitating an effective *Being open* process. This involves focusing on the needs of the patient, their family and carers, and being personally thoughtful and respectful.

Patients who do not agree with the information provided

Sometimes, despite the best efforts of healthcare staff or others, the relationship between the patient, their family and carers and the healthcare professional breaks down. They may not accept the information provided or may not wish to participate in the *Being open* process. In this case, the following strategies may assist:

- Deal with the issue as soon as it emerges;
- Where the patient agrees, ensure their family and carers are involved in discussions from the beginning;
- Ensure the patient has access to support services;
- Where the senior health professional is not aware of the relationship difficulties, provide mechanisms for communicating information, such as the patient expressing their concerns to other members of the clinical team;
- Offer the patient, their family and carers another contact person with whom they may feel more comfortable.
- Use a mutually acceptable mediator to help identify the issues between the healthcare organisation and the patient, and to look for a mutually agreeable solution;
- Ensure the patient, their family and carers are fully aware of the formal complaints procedures;
- Write a comprehensive list of the points that the patient, their family and carers disagree with and reassure them you will follow up these issues.

7.0 Duty of Candour Compliance/Non compliance

These processes are monitored and non-compliance to the Duty of Candour requirements can result in a breach of CQC Regulation 20. The CQC can take enforcement action on the trust such as prosecution, without first serving a warning notice and can be liable to a fine of £2,500.

The commissioners can also:

- Withholding the cost of the episode of care or implementing a fine of £10,000 if the cost is not known. In addition, they can do any/all of the following:
- Send a report to the CQC
- Require that the Chief Executive send an apology and an explanation of the breach to the patient/relatives
- Publish details of the breach on the Trust web-site

8.0 Communication of lessons learned (internally and externally)

Lessons learned from incidents, complaints and claims and the "Being open" and Duty of Candour process will be shared:

Internally - In accordance with Incident reporting and investigation policy, Complaints policy, Claims Management including at a local level through ward/department team meetings and Business group quality board arrangements.
Externally - The incident reports of patient safety incidents are fed through the National Reporting Learning Service to the NHS England and the Care Quality Commission.

9.0 Training

There will be no specific formal training on the policy however; the following training will include the culture and requirements of "Being open" and the Duty of Candour:

- Risk and Safety mandatory and induction training
- Risk assessment for managers training
- Investigation of incidents complaints and claims training.

There will also be ad hoc specialised "Being open" training sessions when funding is available.

10.0 Equality and Diversity Statement

All patients, employees and members of the public should be treated fairly and with respect, regardless of age, disability, gender, marital status, membership or non-membership of a trade union, race, religion, domestic circumstances, sexual orientation, ethnic or national origin, social & employment status, HIV status, or gender re-assignment

11.0 Monitoring

Process for monitoring e.g. audit	**Responsible individual/ group/ committee**	**Frequency of monitoring**	**Responsible individual/ group/ committee for review of results**	**Responsible individual/ group/ committee for development of action plan**	**Responsible individual/ group/ committee for monitoring of action plan**
Via the Six SAE/SUI report. The identification of moderate, serious and death incidents, notification to patients/carers/Next of Kin, timescales and investigations	Head of Risk and Customer Service /Business Group Governance Leads/	6 monthly	Quality Governance Committee/Risk Management Committee	Quality Governance Committee/Risk Management Committee	Quality Governance Committee/Risk Management Committee

If you would like this document in a different format, e.g. in large print, or on audiotape, or for people with learning disabilities, please contact PCS.

Your local contact for more information is Patient and Customer Services at Poplar Suite, SHH, Tel: 0161 419 5678 or

www.stockport.nhs.uk

A free interpreting service is available if you need help with this information. Please telephone Stockport Interpreting Unit on 0161 477 9000. Email:eds.admin@stockport.gov.uk

如果你需要他人爲你解釋這份資料的內容，我們可以提供免費的傳譯服務，請致電 0161 477 9000 史托波特傳譯部。

W przypadku gdybyś potrzebował pomocy odnośnie tej informacji, dostępne są usługi tłumaczeniowe. Prosimy dzwonić do Interpreting Unit pod numer 0161 477 9000.

যদি এই খবরগুলি সম্পর্কে আপনার কোন সাহায্য দরকার হয় তবে বিনা খরচে আপনার জন্য দোভাষীর ব্যবস্থা করা হতে পারে। মেহেরবানী করে স্টকপোর্ট ইন্টারপ্রিটিং ইউনিটে ফোন করুন টেলিফোন নম্বর, 0161 477 9000.

اگر آپ کو ان معلومات کے بارے میں مدد کی ضرورت ہے تو مفت ترجمانی کی سروس دستیاب ہے۔ براہ مہربانی انٹرپریٹنگ یونٹ کو 0161 477 9000 پر فون کریں۔

خدمات ترجمه رایگان این اطلاعات در صورت نیاز موجود میباشد. لطفا با شماره تلفن 0161 477 9000 با واحد ترجمه (اینترپریتینگ یونیت) ما تماس بگیرید.

تنوفر خدمة ترجمة شفوية اذا تطلبت مساعدة في فهم هذا المعلومات. نرجو الاتصال اربن رينيول على رقم الهاتف:0161 477 9000