The Royal Wolverhampton NHS
NHS Trust

OP 81
Same Sex (gender) accommodation

Policy Contents

1. Policy Statement

The purpose of this policy is to ensure that staff are aware and refer to national guidance / policy to maximise patient privacy and dignity, by ensuring patients experience same sex (gender) accommodation.

Following NHSI paper on delivering same sex accommodation guidance this policy will align with itself with these guidelines
Sleeping in the same room or bay as people of the opposite sex is upsetting and uncomfortable for some patients, creating additional anxiety at times of illness and is likely to impact on their recovery. It can also cause concern for families and carers of frail or vulnerable patient, and this can lead to a level of dissatisfaction and an increase in complaints relating to this aspect of care.

Should it be necessary to nurse patients of the opposite sex in the same bay, staff must ensure patients and / or their relatives understand the reasons for doing so, and that every effort is made to maintain the privacy and dignity of those affected.

On occasion it may be necessary to nurse patients of the opposite sex together, this must be in a side room with ensuite facilities. This must only be considered for couples in a relationship and considered to be in the best interests of both parties. This must be discussed with the Matron and Head of Nursing, where this is the case a risk assessment must be undertaken.
This policy applies to all adult patients, all children aged 12 years and over (including children 16 to 17 year olds placed on adult wards) who are admitted to The Trust.

2. Definitions

2.1 Typically, same sex (gender) accommodation is provided: through mixed wards within which men and women are accommodated in separate bays or rooms; same sex (gender) wards, where the whole ward is occupied by men or women only; or in single sex rooms.

2.2 Same sex (gender) accommodation means sleeping accommodation, bathroom and toilet facilities which patients and service users share only with people of the same sex (gender). It applies to all areas of hospitals, except where clinical need takes priority, or where it is in the interests of a group of service users to share and socialise together. Examples of exceptions to this are given in section 5.1.

2.3 Same sex (gender) accommodation also means that men and women must have access to separate toilet and washing facilities, ideally within or next to their ward bay or room and clearly labelled male / female. They must not need to go through sleeping areas or toilet and washing facilities used by the opposite sex to access their own.

2.4 Department of Health guidance dictates that a bay is a single or multi-bedded sleeping area which is fully enclosed on three sides with solid walls. The use of curtains alone between bays does not constitute same sex (gender) accommodation, offering only limited privacy and confidentiality.

2.5 Clinical justification - it will be clinically appropriate in some situations for care to be delivered in a mixed area or urgent treatment to be given irrespective of same sex (gender) accommodation provision. Examples of this are given in section 5.1.

2.6 Trans-gender people (trans men- female to male and trans women- male to female) and (non-binary people) must be addressed and accommodated according to the gender in which they disclose, unless they specify otherwise. The accommodation needs of the patient will be discussed with and met as appropriate, with due regard to the needs of all genders.

2.6.1 Trans people should be accommodated according to their presentation: the way they dress and following a discussion with the patient.

2.6.2 Healthcare professionals should discuss discreetly with patients which pronouns they are to be addressed by.

2.6.3 This may not always accord with the physical sex appearance of the chest or genitalia.

2.6.4 It does not depend on their having a gender recognition certificate (GRC) or legal name change. Staff should not request sight of GRC.

2.6.5 It applies to toilet and bathing facilities (except, for instance, that pre-operative trans people should not share open shower facilities).

2.6.6 Views of family members may not accord with the trans person's wishes, in which case, the trans person's view takes priority.

2.7 Health care professionals must use names, titles, pronouns by which the patient wishes to be addressed by and, wherever possible discuss discretely with patients where they want to be nursed.

2.7.1 Non-binary individuals, who do not identify as being male or female, should be asked discreetly about their preferences, and allocated the male or female ward according to their preference.

3. Mixed Sex Occurrence or breach

3.1 A mixed sex occurrence happens during the placement of a patient within a clinical setting following admission, where one or more of the following criteria apply:

3.2 The patient occupies a bed space that is either next to or directly opposite a member of the opposite gender.

3.3 The patient occupies a bed space that does not have access to single-sex (gender) washing and toileting facilities.

3.4 The patient must pass through or alongside sleeping accommodation designated

for occupation by members of the opposite sex (gender) to gain access to washing and toileting facilities.

3.5 Where no clinical justification exists or where a clinical justification applied is no longer appropriate.

4. Accountabilities

This policy applies to all staff employed at the Trust on a substantive or temporary contract including bank, agency, and locum staff.

4.1. **Patient Flow Manager/Capacity and Patient Flow**
The Patient Flow Manager/Capacity and Patient Flow must be fully conversant with the Same sex (gender) accommodation policy being able to apply the principles to clinical practice. They are responsible for highlighting the pattern of admissions working in conjunction with the ward teams to ensure where possible that the correct sex beds are available within the correct speciality wards.

4.2. **Divisional Healthcare Governance Manager**
Will notify the Head of Information by 5th each month of any breaches from the preceding month.

4.3 **Head of Patient Experience and Public Involvement**
Is responsible for constructing a range of patient experience reports which include delivery against key performance targets for same sex (gender) accommodation. Is responsible for capturing and reporting (to staff, patients and the public) patient experiences of privacy, dignity and same sex (gender) accommodation.

4.4 **All staff members**
Are responsible for ensuring that their attitudes, actions, behaviour and communications are consistently in line with the principles of this policy to ensure patient privacy, dignity and respect is maintained at all times.
Are responsible for alerting line managers where patient privacy, dignity and respect have been compromised so that immediate action can be taken to rectify this.

4.5 **Senior Sister/Charge Nurse / Shift Lead**
The Senior Sister/Charge Nurse/ shift leads are responsible for ensuring that the privacy and dignity of patients is always maintained and that all options are utilised to prevent a breach. Ensure any mixed sex (gender) accommodation breach is recorded in the patients' healthcare records by the nurse in charge of the patient's care and the occurrence reported on Datix. Complete a Root Cause Analysis (RCA) within a maximum time frame of 24 hours of a single sex accommodation breach. This may be delegated where appropriate. The completed RCA should be sent on to Matron, Senior Matron/ Deputy Head of Nursing. Ensure Duty of candour applied where a breach has occurred.

4.6 **Matron, Senior Matron/ Deputy Head of Nursing**
If operational plans require review in light of the RCA findings the Matron/Senior Matron/Deputy Head of Nursing is responsible for overseeing this process ensuring that if relevant, organisational learning is progressed and relevant teams are informed.

The Matron/Senior Matron/Deputy Head of Nursing is required to quality assure the information before forwarding to the Divisional Head of Nursing.

4.7 **Divisional Head of Nursing**

The Divisional Head of Nursing will review the breach, and actions that have been identified. Where there are queries related to a particular breach the Divisional Head of Nursing will liaise with the Divisional Governance lead. Monthly report of breaches will be to escalated to the Director of Nursing and include number of breaches with details of all patients affected.

4.8 **Director of Nursing**

The Director of Nursing will review the Divisional breaches and included in the Director of Nursing report to the Trust board.

5. Policy detail

5.1 Department of Health guidance is that male, female, or trans male / female non-binary patients will not be nursed in a mixed bay, unless when it is recognised that clinical need takes priority over the need for segregation in the following excluded areas:

5.1.1 **Exclusions:**

Integrated Critical Care Unit [ICCU] & Surgical Enhanced Care Unit (SECU), where patients are housed there for clinical reasons, are not considered as a breach. High dependency patients in ICCU & SECU who are awaiting a ward bed are classified as a same sex (gender) breach at 4 hours (***clinically ready to proceed***) post decision to transfer out (see appendix1)

5.1.2 Areas undertaking very minor procedures, including diagnostics, where patients are not required to undress or be otherwise exposed.

5.1.3 All patient nursed in Same Day Emergency Care (SDEC) will be excluded but consideration must still be given to patient's privacy and dignity.

5.1.4 Renal dialysis units, where patients ordinarily remain fully dressed. Renal dialysis patients are offered a choice of segregation and this choice is recorded in their care records. Patients receiving in-patient dialysis (usually wearing night clothing) or are exposed due to dialysis access are within the scope of this policy and same sex (gender) arrangements must be made, unless the patient has declared a preference otherwise.

5.1.5 Children's wards where age-appropriate segregation must be considered the norm for pre-adolescent children. Children aged 12 years old and over must be segregated based on gender and have the use of a designated single sex toilet

5.1.6 Discharge Lounge, where patients await transport home and may be in a mixed waiting area.

6. With the exception of the exclusions listed, all adult inpatients will be nursed in same sex (gender) accommodation.

6.1 Staff must make every attempt to prevent admitting male and female patients to the same bay. Agreement to breach this standard will only be taken by the Directorate Management Team [in hours] and on-call manager [out of hours].

6.2 Should it be necessary to breach this standard the patients and / or their relatives must understand the reasons for doing so and that every effort is then made to maintain the privacy and dignity of those affected. In all these instances steps must be taken to physically segregate the male and female patients by the use of temporary screens, to improve the privacy and dignity of patients. Where a patient expresses concern or unwillingness to be nursed in mixed sex accommodation, every effort must be made to accommodate that patient in same sex (gender) accommodation.

6.3 Clinical areas accommodating extra capacity beds must take account of the principles of this policy and ensure sufficient sleeping and bathroom areas are available to ensure compliance.

7. Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation of this policy require additional revenue resources	No
3	Does the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	No
6	Other comments There are no requirements for additional capital funding in support of this policy, nor ongoing revenue resource. However, the principles of this policy must be incorporated into any clinical area re-design or new build schemes.	

8. Equality and Diversity Risk Assessment

The completion of the equality impact assessment screening tool does not identify any adverse effect for the following equality groups: age, race, disability or religion and belief. The policy specifically recognises gender and trans gender equality groups.

9. Maintenance

The policy will be kept up to date through the central governance monitoring process and any changes or recommendations will be via the Trust Management Team.

10. Communication and Training

Trust wide notification of the availability of this new policy will be communicated from the central governance team and cascaded via the Divisional Governance Managers and Departmental Heads not covered by the Divisional Structures. Awareness of the policy will be introduced at local induction and distribution of updated policy to on-call managers and directors, and Capacity and Patient Flow members.

11. Audit Process

Breaches to the policy must be isolated incidents and be reported via the DATIX system. This requires details of ID's of not only the patient(s) that breached but also the patient(s) who have been affected by the breach. Divisional Healthcare Governance Managers will inform the Head of Information by 5th of each month of any breaches that occurred in the preceding month. Numbers of patients breached will always be more than one because more than one patient is always affected.

The Head of Information completes a monthly central return to the Department of Health via UNIFY2, whereby each Trust is required to outline details of the number of MSA breaches by CCG. Secondly, the information is used for contracting purposes. Details of the patient, who breach, alongside details of other patients who have been affected by the instance of breach, are required to be submitted to the relevant commissioners in order to process any stipulations/penalties which are defined within the agreed contract arrangements.
Performance monitoring of the audit outcomes will occur within the Divisional reporting structures, reported monthly to the Director of Nursing.

Qualitative data will be gathered to measure the effectiveness of this policy via:

- DATIX reporting [trends from incidents, PALS and complaints]
- Family & Friends Test
- National Annual Inpatient Survey

Criterion	Lead	Monitoring method	Frequency	Committee
Number of breeches in same sex (gender) accommodation	Divisional Heads of Nursing	Reported via DATIX	Per calendar month	Trust Management Committee

12.0 References

Care Quality Commission (2019) – Brief guide 27: Assessment of same sex (gender) accommodation Version 3
Department of Health (2007) Privacy and Dignity – A report by the Chief Nursing Officer into mixed sex accommodation in hospitals.
Department of Health (2007) Transgender experiences – Information and support for trans people, their families and healthcare staff.
Department of Health (2010) – CNO letter – Eliminating Mixed-sex accommodation.
NHS England/Improvement – (2021) NHS System Oversight Framework 2021/22
Department of Health (2009e) – The Story So Far: Delivering Same–Sex Accommodation – A Progress Report December 2009. Archived
NHS England (2022)- NHS Standard Contract 2022/23 Service Conditions (Full Length)
Department of Health and Social care (2021) – White paper- Integration and Innovation: working together to improve health and social care for all.
Department of Health Literature Project (2014) – Gender Identity Research & Education Society (gires.org.uk) available at: https://www.gires.org.uk/department-of-health-literature-project Last accessed 15/06/2022
Department of Health (2008)- Trans: A practical guide for the NHS
GOV,UK (2019) -The NHS long-term plan version 1.2 with corrections (August 2019)
NHS England/Improvement 2019 - Monthly Mixed-Sex Accommodation Return: Collection Guidance
NHS England/Improvement (2019) – The NHS Long term plan
NHS England/Improvement (2019 _- Delivering same sex (gender) accommodation (including annex B: Delivering same-ex accommodation for trans people and gender variant children)
RCN 2008 Defending Dignity.

Part A - Document Control

Policy number and Policy version: **OP 81 Version 5.0**	**Policy Title** **Same sex (gender) accommodation policy. (note name change from single-sex)**	**Status:** **FINAL**		**Author: Deputy Chief Nurse – Quality & Safety** **Director Sponsor: Chief Nurse**
Version / Amendment History	**Version**	**Date**	**Author**	**Reason**
	1.0	Nov 2008	Divisional Nurse - Surgery	New Policy
	2.0	Jan 2012	Divisional Nurse - Surgery	Routine review due
	3.0	June 2015	Acting Divisional Nurse - Surgery	Routine review due & ICCU standards 2013
	4.0	March 2019	Associate Chief Nurse	Routine review due
	5.0	May 2022	Head of Nursing, Division 1	Extension until August 2022
Intended Recipients: Heads of Nursing, Matrons, Senior Sister/Charge Nurses, all on-call managers and directors, capacity and patent flow team.				
Consultation Group / Role Titles and Date: Heads of Nursing June - 2022 Matrons - July 2022 Chief Nurse – July 2022 Deputy Director of Nursing – June 2022 Nursing, Midwifery, Health Visiting and Allied Health Professional Leaders Group - July 2022 Capacity and Patient Flow Matron - June 2022 Equality Diversity and Inclusion Lead - July 2022 Patient Experience Team June - 2022 Interim Chair of Transgender LGBT+ Employee Group - June 2022 Head of Safeguarding - July 2022				
Name and date of Trust level group where reviewed	Trust Policy Group – September 2022			
Name and date of final approval committee	Trust Management Committee – September 2022			
Date of Policy issue	October 2022			
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	3-yearly (September 2025)			

Training and Dissemination: Trust wide notification of the availability of this updated policy will be communicated from the central governance team and cascaded via the Divisional Governance Managers and Departmental Heads not covered by the Divisional Structures. Dissemination via Heads of Nursing meeting (for Matrons) on-call managers and directors distribution lists, and at Trust induction to all new starters.	
Publishing Requirements: Can this document be published on the Trust's public page: **Yes** If yes you must ensure that you have read and have fully considered it meets the requirements outlined in sections 1.9, 3.7 and 3.9 of OP01, Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines, as well as considering any redactions that will be required prior to publication.	
To be read in conjunction with: N/A	
Initial Equality Impact Assessment [all policies]: Completed Yes **Full Equality Impact assessment [as required]: Completed Yes**	
Monitoring arrangements and Committee	Compliance is monitored internally, reported monthly through Division to Director of Nursing. Externally, monthly returns & reporting via Head of Performance. Policy Committee.
Document summary/key issues covered. The above policy is a routine review of a previously agreed policy: The purpose of this policy is to ensure that staff refer to national guidance / policy to maximise patient privacy and dignity, by ensuring patients experience same sex (gender) accommodation	
Key words for intranet searching purposes	Same sex accommodation Same sex (gender) accommodation Single sex accommodation Mixed sex accommodation
High Risk Policy? **Definition:** • Contains information in the public domain that may present additional risk to the public e.g. contains detailed images of means of strangulation. • References to individually identifiable cases. • References to commercially sensitive or confidential systems. If a policy is considered to be high risk it will be the responsibility of the author and chief officer sponsor to ensure it is redacted to the requestee.	**No**

Part B **Ratification Assurance Statement**

Name of document: **OP81 Same sex (gender) accommodation policy**

Name of author: Doreen Black Job Title: Head of Nursing, Division 1

I, the above named author confirm that:

- The Strategy/Policy/Procedure/Guidelines (please delete) presented for ratification meet all legislative, best practice and other guidance issued and known to me at the time of development of the said document.
- I am not aware of any omissions to the said document, and I will bring to the attention of the Executive Director any information which may affect the validity of the document presented as soon as this becomes known.
- The document meets the requirements as outlined in the document entitled Governance of Trust- wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines(OP01).
- The document meets the requirements of the NHSLA Risk Management Standards to achieve as a minimum level 2 compliance, where applicable.
- I have undertaken appropriate and thorough consultation on this document and I have detailed the names of those individuals who responded as part of the consultation within the document. I have also fed back to responders to the consultation on the changes made to the document following consultation.
- I will send the document and signed ratification checklist to the Policy Administrator for publication at my earliest opportunity following ratification.
- I will keep this document under review and ensure that it is reviewed prior to the review date.

Signature of Author: 

Date: 02.08.2022

Name of Person Ratifying this document (Chief Officer or Nominee):
Job Title:
Signature:

- I, the named Chief Officer (or their nominee) am responsible for the overall good governance and management of this document including its timely review and updates and confirming a new author should the current post-holder/author change.

To the person approving this document:

Please ensure this page has been completed correctly, then print, sign and email this page only to: The Policy Administrator.

IMPLEMENTATION PLAN

To be completed when submitted to the appropriate committee for consideration/approval

Policy number and policy version	**Policy Title:** OP 81 Same Sex (gender) accommodation policy V5	
Reviewing Group	Trust Policy Group	**Date reviewed:**
Implementation lead: Print name and contact details		
Implementation Issue to be considered (add additional issues where necessary)	**Action Summary**	**Action lead / s (Timescale for completion)**
Strategy; **Consider** (if appropriate) 1. Development of a pocket guide of strategy aims for staff 2. Include responsibilities of staff in relation to strategy in pocket guide.		
Training; Consider 1. Mandatory training approval process 2. Completion of mandatory training form	Not required	
Development of Forms, leaflets etc; Consider 1. Any forms developed for use and retention within the clinical record **MUST** be approved by Health Records Group prior to roll out. 2. Type, quantity required, where they will be kept / accessed/stored when completed	Not required	
Strategy / Policy / Procedure communication; Consider 1. Key communication messages from the policy / procedure, who to and how?	By central governance team and cascaded via the Divisional Governance Managers and Departmental Heads not covered by the Divisional Structures. Dissemination via Heads of Nursing meeting (for Matrons) on-call managers and directors distribution lists, and at	

	Trust induction to all new starters	
Financial cost implementation Consider Business case development	N/A	
Other specific Policy issues / actions as required e.g. Risks of failure to implement, gaps or barriers to implementation		

Appendix 1

Integrated Critical Care Unit (ICCU)

Escalation procedure to avoid Same Sex (gender) Accommodation (SSA) breaches

To be added as an addendum to the Same Sex Accommodation Policy (OP81)

This escalation procedure will be initiated by the Band 7 Floor Leader

1. As part of the daily bed meeting on ICCU at 8.45am, patients are identified as potentially clinically fit for discharge or transfer to another base Ward in the Trust.

2. Following the bed meeting, the Nurse in Charge telephones the Capacity Team to inform them of discharges and transfers for the day. This telephone call typically occurs at 9.15am and is a curtsey call to pre-empt the updating of the Safe Hands Board by the ICCU Team.

3. Patients who are deemed ready for transfer to another ward will have their transfer status updated on the Safe Hands Board which will also note the preferred ward for onward transfer (if appropriate).

4. Named nurse will ensure patient is dismantled, transfer paperwork completed, discharge summary completed, and documentation is completed and filed appropriately. It is at this stage that the “ready to Move button” will be pressed and the clock is started. This is when all medical devices have been removed from the patient and all necessary documentation completed as per the updated NHS Improvement and NICE guidance

5. Following consultant ward rounds throughout the day, any subsequent patients identified for transfer to a ward will follow the same process as identified above.

6. If the identified discharges are not possible within the 4 hour breach time due to capacity challenges within the trust, the Floor Leader must escalate the potential SSA breach to the Matron (or nominated Deputy) for ICCU.

7. Matron will inform the Deputy Chief Operating Officer (or nominated Deputy) for Division 1 and the Head of Nursing for Division 1 of the potential SSA Breach.

8. If the SSA breach has occurred, this should be reported via DATIX in the usual manner by the Band 7 Floor Leader.

9. In accordance with NICE guidelines (CG50 1.14), NO patient will be transferred out from Critical Care Unit between the hours of 22:00-07:00. Any unjustified breaches at 21:00hrs not transferred before 22:00hrs will stop the clock and resume at 07:00hrs. This is only reported as one breach.

10. Any patient receiving End Of Life care should not be moved solely to achieve segregation. In this case a breach would be justified and there is no time limit. A side room will be utilised where possible. (NHS England 2019, NHS Improvement 2019.

Appendix 2

Glossary/definition of useful terms

Cross-dresser
The term 'Cross-dresser' refers to people who choose to wear clothing usually associated with the opposite gender Most people who are cross-dressers do not experience any discomfort with their gender identity and do not wish to transition their gender role. Nor do they usually seek modification of their bodies. The term 'transvestite' is associated with cross dressing, though some cross dressers would not identify as such and the term is not commonly used.

Gender / Cisgender
Gender consists of two related aspects; the person's internal perception of who they are is the 'gender identity'; the way the person behaves and lives in society and interacts with others is the *gender role or expression*. The term 'cisgender' applies to people whose gender identity at birth remains unchanged in subsequent life and which they (broadly) adopt.

Gender reassignment
Under the **Equality Act 2010 (EA10**), a person has the protected characteristic of *gender reassignment* if they are proposing to undergo, are undergoing or have undergone a process (or part of a process) for the purpose of reassigning their sex by changing physiological or other attributes of sex. This is a personal process that may involve medical interventions such as counselling, psychotherapy, hormone therapy or surgery, but does not have to.

Gender Recognition Certificate (GRC)
The Gender Recognition Act provided for the legal recognition of the trans person in their 'acquired' (i.e.affirmed) gender and the opportunity to acquire a new "birth" certificate for their new gender. This is called a Gender Recognition Certificate and replaces the original birth certificate in all official documentation.

GRS – Gender Reassignment Surgery
Surgery to change gender. An individual must complete live continuously in the gender role that matches the intended gender identity for 12 months before undergoing genital surgery. Some other procedures, such as chest surgery may be undertaken before this stage, and others after, according to the needs of the individual undergoing reassignment. Surgery is not obligatory to reassign gender.

Transsexual
An adjective that describes people whose sex, as registered at birth, is not congruent with their current gender identity. Usually, people respond to their discomfort by undergoing a personal process of gender reassignment to bring their outside characteristics and their gender expression, in line with their gender identity. The word transsexual is not often used by people who may be so described, because they prefer the terms 'trans' or 'transgender'. Those that have completed the process may regard themselves as men or woman, having resolved the conflict between their gender identity and gender expression.

Also used by **EA10** to define people who fall within the definition of those people with the protected characteristic of gender reassignment (above).

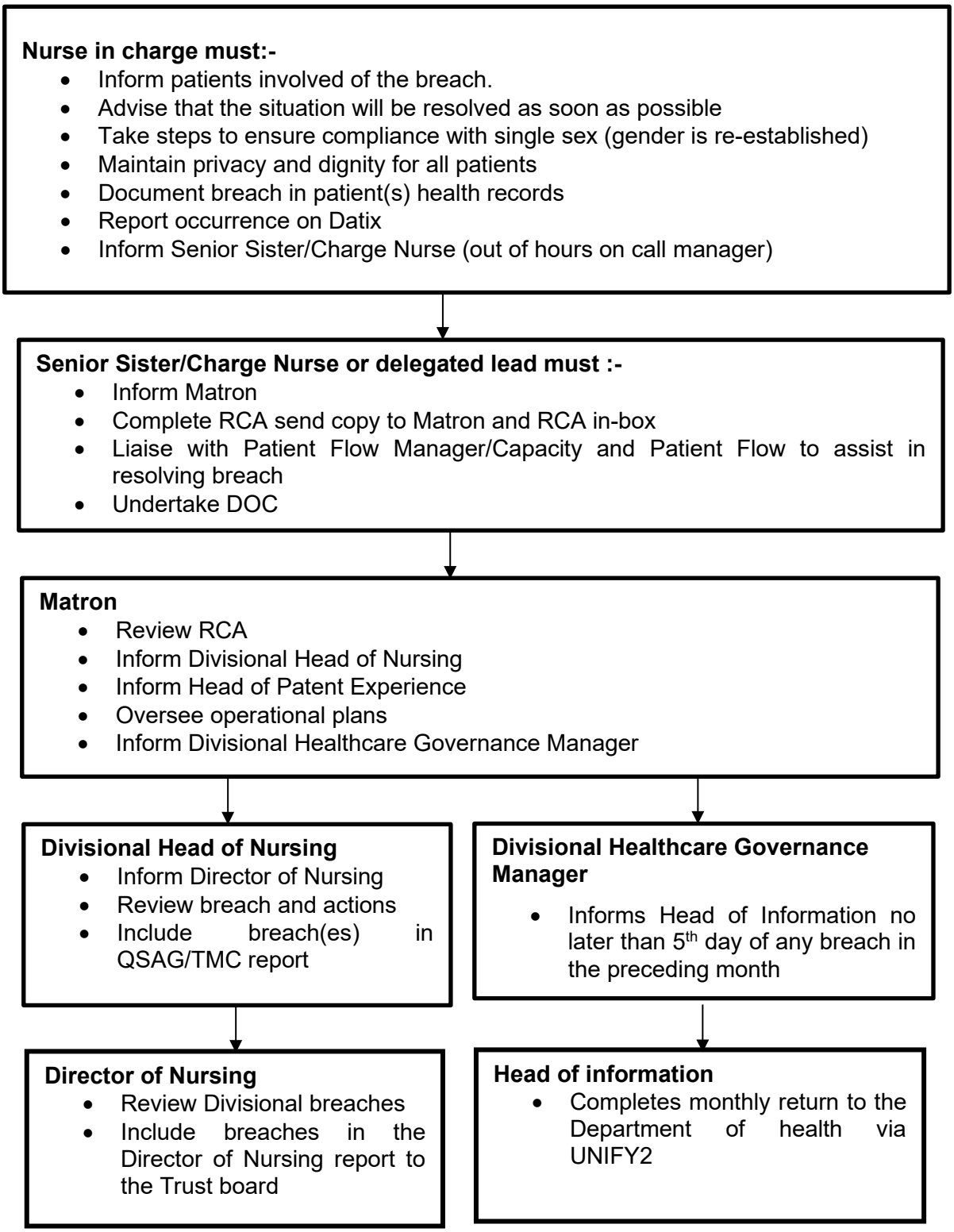
Transgender (often abbreviated to 'trans')
This is often used as an 'umbrella term' to include all people who experience gender dysphoria and express this in some way. *Transgender* includes transsexual people but is much wider to embrace a wide variety of gender expression including those who have no intention of permanently changing gender role and may use a variety of self-descriptions, such as poly-gender, pan gender, gender queer. A few do not identify as either men or women and are non-gender.

Trans Man
A trans man is a person who was registered female at birth, but who identifies as a man. FtM (female to male) is convenient, but rather impolite shorthand

Trans Woman
A Trans woman is a person who was registered male at birth, but who identifies as a woman. MtF (male to female) is convenient, but rather impolite shorthand

Appendix 3

Process following breach of single sex (gender) accommodation



Appendix 4

Letter to be sent to patients (Duty of Candour Element's 1 & 2)

Name

PRIVATE AND CONFIDENTIAL

Dear **(insert name)**

[As discussed during our meeting/ telephone conversation on [DATE]] / I am writing to inform you of an incident that occurred during your/ your **(insert description of relative)** care. *[Give brief description of incident including date].*

I am very sorry that this incident occurred. When things like this happen we are committed to being open and honest with you, and to keep you informed as to what further action we are taking.

There will be an investigation to look at the care and treatment that **you/ (insert name)** received from us. The purpose of the investigation is to better understand the circumstances which led to this happening. In some cases this can identify ways that we can learn and improve, or provide reassurance about the care and treatment that you received. Also the investigators can consider any questions or concerns that you might have, which may be included as part of the investigation.

When our investigation is complete you will be contacted within 10 working days to discuss the investigation findings. If you do not wish to receive the outcome of this investigation please contact me so that we can record this appropriately to ensure that you are not contacted again.

(Include if appropriate) Please be assured that it is not our intention to intrude upon you or your family at what must be a very difficult time. It is, however, important that we keep you informed. The Trust is fully committed to open and honest communication with patients and or their relatives or carers where incidents occur; and for our patients to be confident that we react quickly and responsibly to put things right.

I / (or insert name) will be your named contact throughout this process. If you would like to discuss anything in this letter, tell us any questions you have for the investigation, or to advise us that you do not wish to be involved, please contact me / **(or insert name)** on 01902 307999 (**ext: …).**

Yours Sincerely

Enclosed*: Duty of Candour Patient Information Leaflet*

Name

PRIVATE AND CONFIDENTIAL

Dear **(insert name)**

Further to our previous conversation on…/ meeting on…/ letter dated, I write to advise you of the outcome of the investigation into the incident involving your **(delete/insert name of relative if appropriate)**

We would like to take this opportunity to apologise again that this incident occurred. The Trust takes every patient safety incident seriously and has conducted a full investigation to identify if there were any contributory factors to explain why the incident occurred or determine whether the incident could have been prevented.

Please find below a summary of the investigation findings.

- *Summary of events and facts*
- *A summary of the patients'/ carers' concerns and complaints (if applicable)*
- *Investigation Findings (i.e. Root Causes, whether or not it was preventable etc.)*
- *A summary of the significant factors which have contributed to the incident*
- *Lessons Learnt*
- *What has been done or is going to be done to reduce the chance of recurrence and how this will be monitored (overview of* Action plan)

I hope that this will help assure you that the appropriate steps have been taken to identify any care or treatment issues relevant to the incident, and that appropriate recommendations have been implemented to prevent recurrence.

If you have any queries or wish to discuss this further, please do not hesitate to contact me on **(insert contact number)**

Yours Sincerely