Royal College of Surgeons' response to CQC consultation on Guidance for NHS bodies on the fit and proper person requirement for directors and the duty of candour

August 2014

Our response focuses exclusively on the Duty of Candour requirement

We are pleased that CQC has recognised that it will need to take a proportionate approach to inspecting and enforcing the Duty of Candour regulation. When this duty needs to be enforced it marks a failure to address harm or failure in a constructive way. Cultural change is required to facilitate greater openness in the NHS, not just procedural changes.

In carrying out these duties, CQC should consider a range of different sources of evidence, including how well an organisation identifies and responds to harm, and how it supports staff to disclose harm to patients and their carers. CQC should also look for patterns in organisational behaviours as well as scrutinise individual cases.

We welcome the inclusion of guidance on how an organisation should deal with a safety incident that might have happened some time ago, including in relation to another provider. We support CQC's guidance which suggests that the provider which discovers the incident takes responsibility for ensuring that patients are notified of the safety incident; whether by the organisation that discovers the incident or the provider where the incident occurred. We believe it is also essential that these organisations work together to explore how such an incident can be prevented in future. We believe the CQC should look closely at how well organisations that are likely to be in the position of discovering harm done elsewhere in the system are set up to ensure that these safety issues are managed, and in particular, how well disclosure to patients and service users is done in cases of this kind.

We are also pleased that CQC recognises that although criminal sanctions have a role to play, by themselves they are unlikely to be the strongest driver for promoting a culture of openness. The RCS believes that incentives that focus on reputation are more likely to be effective than those that have a financial or criminal impact.

The RCS supports the CQC's intentions for its operational guidance for inspectors to seek to encourage (and where appropriate require) good practice in these areas. We support this intention, although the guidance documents do not make clear how this will be done. We would expect the CQC to build up over time an understanding of best practice and borderline cases to support local organisations to make good decisions about candour and the processes they have in place. We welcome the CQC's expectation that providers should also take account of other relevant guidance that might be specific to the service they deliver, including guidance produced by clinical and professional bodies. The RCS is keen to support the CQC in working with providers to help improve services and share best practice. For example, where it is clear from a CQC visit that a further detailed analysis of a surgical service is required, the RCS is happy to provide this to the Trust on request through an invited review. There is already significant information available on good practice - the key challenge is in ensuring improvement action actually takes place.

We believe that the CQC should provide further guidance to providers on how to ensure that *"Staff understand their responsibilities in identifying and reporting notifiable incidents."* We believe the guidance should be developed to encourage providers to ensure that there is education and training in place to reinforce the importance of candour among staff, help them understand their responsibilities, and provide them with the skills and confidence they need to have candid conversations. Furthermore, as part of its assessment we encourage CQC to look at how well organisations are providing the right support and training to staff, while bearing in mind that organisations and their staff will need time to understand and apply the new duty.

The draft guidance suggests that *"Any correspondence from relevant person(s) relating to the incident should be responded to in an appropriate and timely manner."* We believe patients should have a clear indication of when investigations into a safety incident will begin, and that this guidance needs to be further developed. Under the NHS Constitution, patients have the right to have any complaint they make about NHS services acknowledged within three working days. We believe that correspondence regarding a safety incident should also be acknowledged within this timescale and that the acknowledgement should outline the timescale within which an investigation into the safety incident will begin.

The draft guidance also suggests that *"Where a provider becomes aware that staff have not acted in accordance with the requirements place on them under the Duty of Candour they must refer the individual(s) concerned to their relevant professional regulator/body, police, other relevant body etc."* We believe the guidance must make clear that providers must have a system in place which enables it to deal with individual breaches of the duty in a proportionate manner. When a provider becomes aware of a breach it should work to an agreed internal escalation and investigation process. CQC should provide guidance on such processes to ensure that all providers are dealing with investigations in a proportionate manner, which takes into consideration the degree of harm and the extent to which a breach was an act of commission or an act of omission. Following the completion of this process, providers should report the individuals concerned to the relevant body and work in collaboration with that body as part of any investigation.

We strongly believe that candour cannot be simply a matter of compliance. It will only be effective as part of a wider commitment to safety, learning and improvement. Therefore we believe that organisations should give particular focus to taking action to improve safety in light of incidents of harm in order to 'close the audit loop' and put in place a sustained improvement in safety for patients. This is something we encourage CQC to look for when assessing how well an organisation is doing to create a culture of safety and improvement

We believe it is important that CQC recognises it will need to adapt as it learns and as organisations become familiar with the duty. CQC may need to adopt a phased approach to maximise learning and improvement for providers, and as the CQC develops its approach it should share this with providers and others.