13 December 2013

**Duty of candour – review of threshold**

In the recent response to the Mid Staffordshire Public Inquiry, the Secretary of State has invited David Dalton, Chief Executive of Salford Royal NHS Foundation Trust, and I to review the threshold for the new statutory duty of candour, and whether it should be set at the level of death and serious injury or death, serious injury and moderate harm. We are working to a tight timescale, and have decided that to shape our views we need evidence sessions with key players in the field of candour and patient safety.

We would like you to attend a session with the review team during January or February at the Royal College of Surgeons so we can hear your views on the issue. A couple of organisations will be invited together to each session to ensure we have a good round table discussion on the key issues. You will be contacted to agree a suitable date. If you have papers you want the review team to read, please could you e-mail them the week beforehand to mailbox: candourthresholdreview@dh.gsi.gov.uk. We plan to put your papers on the Royal College of Surgeons website after your evidence session.

**The key issues we would like you to address in your evidence session is:**

* What is your overall view on where the duty of candour threshold should be set – death or serious injury, or death, serious injury and moderate harm? Please give reasons for your view.

In particular, we would welcome your views on:

* + should the new duty of candour use the definitions that apply to the reporting of patient safety incidents in the existing National Reporting and Learning System (NRLS), and the existing contractual duty of candour?
	+ The Government response to the Mid Staffordshire Public Inquiry ‘Hard Truths’ said that ‘The professional regulators will develop new guidance to make it clear professionals’ responsibility to report ‘near misses’ for errors that could have led to death or serious injury, as well as actual harm, at the earliest available opportunity and will review their professional codes of conduct to bring them into line with this guidance’.   What is your view on how incident reporting by an individual professional would be made to work best alongside the new statutory duty of candour on organisations?
	+ what is your view on how the duty on the organisation to report an incident, which resulted in death or serious injury/moderate harm to a patient/family, may take account of incidents which have not been reported by a staff member or were not known at the time and were subsequently discovered to have occurred?
	+ how do you make a duty of candour work in primary care, eg for a single-handed practitioner?
	+ do you have any views on the proposal that the NHS Litigation Authority should adjust its contribution according to how candid a Trust has been, and require a contribution to the claim from the Trust?

Yours sincerely

**Norman S Williams David Dalton**

**President Chief Executive**

**Royal College of Surgeons Salford Royal NHS Foundation Trust**