Evidence Submission

Duty of candour – review of threshold

MPS welcomes the opportunity to provide our views on the appropriate threshold of harm for the new duty of candour. MPS has called for a culture of openness in the NHS for several years and we have expressed concerns about the introduction of a statutory duty of candour and how it may impede that culture change.

Our views can be read in full in our publication *A Culture of Openness*[1] and below we have set out our views in relation to the specific questions from the review.

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.

The criticism of healthcare professionals at Mid Staffordshire was that they failed to report serious incidents and that there should therefore be stronger legal obligations to report these backed by sanctions. However, there are risks to legislating to create a duty of candour and MPS thinks the threshold should be set at death or serious injury in order to mitigate these risks.

Administrative burden and compliance culture

In general, legislation is not the appropriate way to create safe, responsive, patient-centred care and high quality communication between professionals and patients. Statute is a blunt instrument and cannot create the open, transparent, learning culture that the NHS needs and can in fact impede this change by creating a compliance and reporting culture instead.

For any statutory duty to be effective there need to be systems for monitoring compliance and sanctions for non-compliance. Any such system will inevitably distract from the original objective of ensuring openness with patients and learning from mistakes by incentivising tick box compliance rather than high quality communication. It also creates nervousness and fear amongst professionals about complying with legislation.

A lower threshold would mean many more instances of a duty to report, a more extensive administrative system to monitor this and more confusion, inconsistency and fear amongst professionals due to the subjective judgments needed for lower levels of harm.

[1] Medical Protection Society, *A Culture of Openness,* (June, 2011) http://www.medicalprotection.org/uk/booklets/a-culture-of-openness

Subjective judgments of the degree of harm

The threshold should be set so as to minimise any possible subjective interpretation of when the duty is engaged and there is a greater degree of subjectivity in judging the degree of harm for lower levels of harm (i.e. whether harm was low or moderate).

A low threshold would therefore place undue pressure on practitioners to have to make these more subjective judgments knowing their decision could entail a statutory obligation to report the incident. It would lead to confusion and inconsistency and fear amongst professionals about their judgments being later criticised.

It is important that there is clarity for organisations and professionals as to when their statutory duty will be engaged. MPS has seen the uncertainty sometimes facing practitioners when legal obligations are not clear and the consequences of this for patients. A threshold of death or serious injury, defined as permanent harm to a patient, is clear and unequivocal and would avoid the inconsistency and fear created by a lower threshold.

Existing duties

There may be concerns that restricting the duty to a higher level of harm will mean patients will not be entitled to be informed about all incidents which affect them. However, it should be noted that there are other obligations to be candid with patients. There are professional obligations, which the regulators are currently looking to strengthen, and also contractual obligations.

The new duty should act only as a final legal safeguard in the most severe cases to establish a requirement that patients are informed of the most serious incidents of error.

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?

Whatever source is used, definitions and standards should be consistent across professional, organisational and contractual duties and obligations to ensure that expectations are clear. These should also be kept as simple as possible for clarity.

There are already inconsistencies in the way organisations report degrees of harm to the NRLS and this highlights the need for the statutory duty to apply the more objective thresholds of death or serious injury.

With a lower threshold there will always be inconsistencies in the way incidents are reported by degrees of harm due to the subjective nature of judging which category an incident falls into. The uncertainty this creates makes a lower threshold inappropriate for a statutory duty.

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?

Organisations must recognise that professionals have broad responsibilities to report incidents (to employer, regulator, commissioner etc) and must support their employees to fulfil their professional responsibilities. They must also be clear to employees as to what is expected of them to enable the organisation to in fulfil its statutory responsibilities.

Organisations should encourage openness and transparency in all circumstances and have straightforward systems to record incidents. They should then take decisions at the organisational level as to whether statutory obligations are being fulfilled and what further disclosures may be required to fulfil them.

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?

The duty needs to set reasonable reporting expectations and take into account latent error – it will only be reasonable for organisations to disclose incidents when they are aware of them.

It will be important to create a culture of learning and improvement rather than one of blame for professionals when harm from errors is later discovered. The need to comply with legislation and the tendency to blame when this does not happen is a risk of legislating in this way. A higher threshold will reduce the risk of this becoming a more widespread problem and fatally undermining the drive to a more open culture.

How do you make a duty of candour work in primary care, eg for a single-handed practitioner?

There are big challenges in primary care that are different from those in secondary care. Practitioners can be more isolated and have less contact with structures and systems that can facilitate disclosures.

To reduce the administrative burden responsibilities, standards and definitions need to be clear, and existing structures and processes should be used to audit compliance – e.g. revalidation and CQC inspections and practice ratings.

It would also make it clearer for GP practices when the duty was engaged if the threshold was set at death or serious harm.

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?

MPS does not in general think it appropriate to use financial incentives via NHSLA to encourage particular behaviours. This would create additional administrative requirements and would not impact on primary care.

The focus should be on creating an environment of learning and improvement in trusts, not blame and sanctions, and this should be reflected in hospital ratings.

About MPS

The Medical Protection Society is the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and health professionals around the world.

We are a mutual, not-for-profit organisation offering more than 280,000 members help with legal and ethical problems that arise from their professional practice. This includes clinical negligence claims, complaints, medical council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal-accident inquiries.

Fairness is at the heart of how we conduct our business. We actively protect and promote the interests of members and the wider profession. Equally, we believe that patients who have suffered harm from negligent treatment should receive fair compensation. We promote safer practice by running risk management and education programmes to reduce avoidable harm.

MPS is not an insurance company. The benefits of membership are discretionary - this allows us the flexibility to provide help and support even in unusual circumstances.

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