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Royal College of Surgeons

Statement on Duty of Candour

ADVANCING SURGICAL STANDARDS

RCS Statement on Duty of Candour

Candour and openness are a fundamental part of what it means to be a healthcare professional. To drive up standards of care, professionals and organisations need to be honest about their mistakes in order to quickly deal with errors and learn from them. Candour also allows the public to understand why decisions have been made, encouraging patients to be involved in their care. Openness and transparency need to be led by the top of the organisation to engender real culture change and drive professionalism in the NHS.

Where should the duty of candour threshold be set?

We believe that the threshold should be set to include what is described as 'moderate harm'. Patients deserve to be given as full a picture as possible of their care, and they should be told about incidents that do not fall into the 'severe' category but which would still be important to them to know. The National Reporting and Learning Systems' (NLRS) definition of moderate harm includes incidents that have caused 'significant but not permanent harm'. Non-permanent harm could still last for many years and to a patient is not likely to be regarded as a 'moderate' incident in any way. We believe it is not tenable to have a healthcare system which would keep from patients knowledge of harm which could cause suffering or change their lives.

We also feel that by implementing a culture of candour, it would only be natural to move to this level to enable organisations to embrace more openness and usher in a learning environment. A duty of candour in the NHS needs to facilitate, rather than inhibit, cultural change. We believe setting the threshold at 'moderate harm' would help to achieve this.

One of the problems in assigning a threshold is that the meaning of 'moderate harm' can represent different things to clinicians and patients. It is important therefore that the NHS agrees on a clear set of definitions and these are explained clearly to patients in order to remove ambiguity and bring in the correct reporting systems. The definitions used by the

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NLRS are widely used and we would not want to see a move too far away from them. The existing contractual duty of candour requires disclosure of all incidents where harm is done, so the individual duties need to be aligned to the organisational needs, even if they are set at different levels.

Professionals' responsibility to report duty of candour

To help achieve a cultural change of greater openness in the NHS it is essential that the new organisational duty of candour enables and encourages doctors and nurses to be open and candid in their own conversations with colleagues and patients.

There needs to be greater clarity in the way the new organisational duty is brought in, and we would expect to see Trusts explaining and educating staff on what the new duty means. Surgery is reliant on the work of multi-disciplinary teams and thought needs to be given as to how a new organisational duty will encourage and support the educational and learning environment.

All doctors have a professional, moral and ethical duty to be open and honest with their patients at all times. It is the responsibility of the clinical team - led by the most senior clinician involved - to make a judgment about disclosure, which should be personalised according to the needs of the individual patient. The College regards the quality and manner of this disclosure with patients to be a critically important aspect of clinical practice.

Good Surgical Practice (patient communication, section 4.4) states that surgeons must:

• fully inform the patient and their supporter of progress during treatment;

• explain any complications of treatment as they occur and explain the possible solutions; and

• act immediately when patients have suffered harm and apologise when appropriate.

How to take account of incidents not known or reported at the time but subsequently discovered to have occurred further down the line

This will be a great challenge for all organisations and is possibly one of the most contentious areas of the new Duty. In some cases, it may transpire many years after an event that harm has occurred but was not reported at the time, either deliberately or through oversight. The passing of time is not a reason by itself to decide not to inform a patient, however. Indeed, it could become essential to inform a patient because their health may have deteriorated significantly during that period.

We would expect trusts to set up a system to deal with this kind of non-reporting event, but most importantly, to educate staff on how to work within that system. It is important that all clinical staff know that non-reporting has significant consequences. Only in doing so will a culture of candour to be brought into the NHS.

See here for the findings of the full review, co-chaired by RCS President Norman Williams.