THE DUTY OF CANDOUR

Gabriel Beeby & Selena Plowden

Guildhall Chambers

Guildhall
CHAMBERS

Patient Safety

Guildhall
CHAMBERS

What do patients want?

*TO BE TOLD **HONESTLY** :*

1. *WHAT HAPPENNED?*
2. *WHAT CAN BE DONE TO DEAL WITH THE HARM?*
3. *WHAT WILL BE DONE TO PREVENT RECURRENCE TO SOMEONE ELSE?*

Guildhall
CHAMBERS

The extent of the candour

- THE VOLUNTEERING OF ALL RELEVANT INFORMATION TO PERSONS WHO HAVE OR MAY HAVE BEEN HARMED

- WHETHER OR NOT THE INFORMATION HAS BEEN REQUESTED AND WHETHER OR NOT A COMPLAINT HAS BEEN MADE

Guildhall CHAMBERS

Who should be candid?

- INDIVIDUAL CLINICIANS / HEALTHCARE STAFF
- HEALTHCARE ORGANISATIONS

Guildhall CHAMBERS

Perceived obstacles

- Misplaced paternalism
- Fear of loss of reputation
- Fear of litigation

Guildhall CHAMBERS

The role of tort law

Some recognition of the possibility that there is a duty of openness/disclosure recognised in:

Lee v South West Thames Regional Health Authority [1985] 1 WLR 845

Naylor v Preston [1987] 1 WLR 958 at 967

Guildhall CHAMBERS

Robbie's Law

Powell v Boladz [1983] 39 BMLR 35

Powell v UK application No 45305/99 4 May 2000 European Court of Human Rights

Welsh Government investigation 2012

Guildhall CHAMBERS

The individual Clinician: Ethical and Professional Duties of Candour

- The moral/ ethical basis for being honest with patients is probably self evident.

- The professions have long recognised it in their guidance for example:

Good Medical Practice 2001 – "*if a patient under your care has suffered serious harm … you should act immediately to put matters right.. you should explain fully to the patient … when appropriate you should offer an apology*… "

- This was updated and strengthened in 2006 after the *Powell* case and in 2013 has been updated and strengthened further.

- Under the current Good Medical Practice 2013, doctors are obliged to act in accordance with the GMC guidance "Raising and Acting on Concerns about Patient Safety".

- GDC/NMC Codes of conduct suggest similar

Guildhall CHAMBERS

Broadening the ethical duty to encompass organisations:

The National Patient Safety Agency

The Care Quality Commission

The NHS

The NHSLA/ Welsh Risk Pooling

Guildhall CHAMBERS

The Patient Safety Agency

- Being Open – 2005, 2009 –

"*Being Open*" involves:

- Acknowledging, apologising and explaining when things go wrong;
- Investigating the incident and reassuring patients/families that lessons will be learned for the future;
- Providing support for those involved (physical/ psychological)

Guildhall
CHAMBERS

A best practice framework

- Public commitment
- Leads
- Systems
- Policy
- Training

Guildhall
CHAMBERS

Being Open

- Detailed guidance as to processes for identifying and investigating incidents as well as to means of communicating/ apologising / improving etc …
- The processes were not to be triggered where an incident is avoided. Low harm incidents trigger a discussion. Moderate or severe harm or death trigger the "*Being Open Process*".
- Each Trust will have such a policy.

Guildhall CHAMBERS

Care Quality Commission

CQC registration regulations impose a duty on health service bodies to disclose incidents to the NPSA/ NHS Commissioning Board, Special Health Authority.

BUT:

No duty to tell patients

Guildhall CHAMBERS

The NHS

The NHS Constitution (2009, 2013)

The Secretary of State and all providers and commissioners of NHS care have a statutory duty to have regard to the NHS Constitution in all their decisions and actions (The Health Act 2009, The Health and Social Care Act 2012)

- Rights
- Pledges
- Expectations of staff and of patients

Guildhall CHAMBERS

The “candour” promises:

- to acknowledge mistakes, apologise, explain what went wrong and put things right quickly and effectively;

- the organisation will learn lessons from complaints and will use them to improve NHS services.

Guildhall
CHAMBERS

Expectation of staff

To aim to be open with patients, their families, carers or representatives including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly in a spirit of co-operation.

You should contribute to a climate where truth can be heard and the reporting of and learning from errors is encouraged.

Guildhall
CHAMBERS

Good enough?

Many thought so.

MDU 2009:

We do not support the recommendation…. the inference of the recommendation is that no effective duty of candour currently exists, but this is not the case for doctors who already have an ethical duty and our experience is that doctors do raise concerns.

Guildhall CHAMBERS

The ethical duty in practice

- A National Audit Office report in 2005 revealed that only 24% of English hospital trusts routinely informed patients who had been victims of adverse incidents.
- Ombudsman's report 2011- 2012 complaints reviewed – common pitfalls:
    - Equivocal language/ sitting on the fence
    - Getting key facts wrong
    - Use of technical language without appropriate explanations
    - False or insincere apologies

Guildhall CHAMBERS

The ethical duty in practice...cont/d

- Sir David Dalton/ Prof Williams report March 2014 para 20:

  "We know that levels of reporting do not reflect the actual level of harm that occurs in healthcare…on average most studies have found that reporting systems only receive reports of around 7 -15% of all incidents that are identified through more intensive retrospective review processes.

Guildhall CHAMBERS

Mid Staffordshire – Francis QC Reports

- "*The inquiry identifies a story of terrible and unnecessary suffering of hundreds of people who were failed by a system which ignored warning signs of poor care and put corporate self interest and cost control ahead of patients and their safety*"
- 2013 report: 290 recommendations. Essentially 4 categories:

1. Structure of fundamental standards and measures of compliance;
2. Openness, transparency and candour throughout the system underpinned by statute;
3. Improved support for compassionate caring;
4. Stronger healthcare leadership;

Guildhall CHAMBERS

Mid Staffordshire – Francis QC Reports

Duty of Candour:

- A statutory duty to be truthful to patients where harm has or may have been caused
- Staff are obliged to make their employers aware of incidents in which harm has or may have been caused
- Criminal offence: deliberate obstruction of these aims
- CQC should police the obligations

Guildhall CHAMBERS

The Government's response: Clwyd/Hart

- "Review of the NHS Complaints system – Putting Patients Back in the Picture" October 2013
- Remit – to consider the handling of concerns and complaints in the NHS
- More advice and recommendations
- Further review this Autumn on the need for "A Commissioner for Complaints Reform"

Guildhall CHAMBERS

Health Secretary's Response

"Duty of candour

1.—(1) If a reportable patient safety incident occurs, or is suspected to have occurred, the service provider must, in accordance with this regulation, provide to the relevant person all necessary support and all relevant information in relation to that incident. …

Guildhall
CHAMBERS

But:

“reportable patient safety incident” means any unintended or unexpected incident that occurs in respect of a service user during the provision of a regulated activity that led to severe harm to, or the death of, the service user;”

Guildhall CHAMBERS

Severe / Moderate Harm

The NHS definition of “severe harm” is:

“Any patient safety incident that appears to have resulted in ***permanent harm to one or more persons receiving NHS-funded care”.***

Guildhall CHAMBERS

NHS definition of Moderate Harm:

"Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care."

Guildhall
CHAMBERS

The Contractual Duty of Candour

- 2014 - Standard term 35
- Provision of information to patient if a reportable incident occurs or is suspected to occur
- Instigate and conduct full investigation asap
- Notify and apologise where appropriate
- Record
- Co-ordinating commissioner may report to CQC / require formal/public explanation/ apology

Guildhall CHAMBERS

Application of contractual terms

Not Primary care

What degree of harm?

What about putting it right?

Guildhall CHAMBERS

AvMA's response

Guildhall CHAMBERS

6th March 2014 report by Sir David Dalton and Professor Norman Williams

The duty of candour should apply to all cases of significant harm. This new composite classification would cover the national reporting and learning system categories of “moderate, severe and death”; harm that is notifiable to the CQC; and would include “prolonged psychological harm”. This is line with the “Being Open” guidance.

Guildhall CHAMBERS

The sting in the tail for claimants

Over the long term we would encourage the Government to consider how it can ensure that the legal system is most able to support a culture of candour. In particular, it could be helpful to minimise the possibility that explanations given as part of a process of candour or open disclosure are then used in evidence to support an admission of negligence…

Guildhall
CHAMBERS

Principled?

1. *Fear of litigation is clearly not a principled argument against candour. Something that is not in your interests can still be the right thing to do.*
2. *It is also a bad practical argument. Individual acts of candour may encourage others to legal action, but the aggregate effect of greater candour on levels of litigation is unlikely to be significant.*
3. *If organisations really put candour in to practice, the real gains come in preventing drawn out cases where legal action is really an expression of the intensity of the desire to know what happened rather than an attempt to secure financial redress.*

Guildhall
CHAMBERS

Where are we now?

Guildhall
CHAMBERS

Guildhall
CHAMBERS