The Duty of Candour

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avma
action against medical accidents

for patient safety and justice
WHAT IS AvMA?

- The independent UK charity for patient safety and justice
- Provides advice and support to individuals affected by a medical accident
- Works in partnership with NHS, private healthcare, health professionals, Gov’t departments and lawyers
- Helped secure the Mid Staffs inquiry & recommendations – especially Duty of Candour
What patients want

- Patient Safety
- Justice
- Better (not more) regulation
- And, increasingly…….
Openness & Transparency

- Information to make informed decisions
- Comparative data / qualitative information
- Information about anything significant in their treatment
- Especially if something goes wrong
Sir Liam Donaldson

“To err is human, to cover up is unforgivable, and to fail to learn is inexcusable”
SOBERING FACTS

- UNTIL November 2014 A HEALTHCARE ORGANISATION WAS NOT IN BREACH OF ANY STATUTORY RULE IF IT ‘COVERED UP’ A MEDICAL ACCIDENT
- THE SYSTEM *FROWNED UPON* BUT TOLERATED COVER UPS
Arguments ("excuses"?) given for not having a legal Duty of Candour

- "It isn’t needed – we are already being open"
- "You can’t change culture or behaviour by law/regulation – just need to wait"
- "Would lead to increased litigation which we can not afford"
- "The public interest is better served by allowing non-disclosure so as to get more reports"
Lack of openness & honesty results in:

- Severe emotional stress and psychological harm to the patient /family. **Injustice**
- Failure to recognise problems and improve **patient safety**
- For staff: “carrying a monkey on your back”; possible regulatory action
- **Increased** likelihood of complaints and litigation
Duty of Candour ("Robbie’s Law")
Where are we now?

- From November 2014 clear statutory (legally enforceable) duty to tell patients / their families when harm is caused
- Contained in Care Quality Commission “fundamental standards” – apply to NHS bodies now
- From April 2015 new regulations apply to primary care & private sector as well
Oops!

THERE IS A PROBLEM!
20. (1) A health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

As soon as reasonably practicable after becoming aware that a **notifiable safety incident** has occurred a health service body must—

- notify the relevant person that the incident has occurred in accordance with paragraph (3), and
- provide **reasonable support** to the relevant person in relation to the incident, including when giving such notification.
“notifiable safety incident” means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in—

- the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user’s illness or underlying condition, or
- severe harm, moderate harm or prolonged psychological harm to the service user;
any unintended or unexpected incident appears \textit{to have resulted} in... a) the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition,

- an impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days,
- changes to the structure of the service user's body,
- the service user experiencing prolonged pain or prolonged psychological harm, or
- the shortening of the life expectancy of the service user; or
- requires treatment by a health care professional in order to prevent—
  - the death of the service user, or
  - any injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a).
CQC Guidance

- CQC Guidance does not differentiate:

Changes from 2015

- Consultation late 2015 on a single set of consistent regulations across whole of NHS and primary care
- Regulations to take effect April 2016
Moderate Harm

“moderate harm” means—

– harm that requires a moderate increase in treatment, and
– significant, but not permanent, harm;

“moderate increase in treatment” means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care);
“Known complications”

- Are **NOT** exempt
- There is a difference between known “risks” and “expected” outcomes
- What if something happens which increases risk / causes a known complication?
- Reasonableness test: would you expect to have been told? Would you be embarrassed if patient found out another way?
Reasonable Support

“Providing the relevant person with information about available impartial advocacy and support services, their local Healthwatch and other relevant support groups, for example Cruse Bereavement Care and Action against Medical Accidents (AvMA), to help them deal with the outcome of the incident.”
Other providers and old incidents

“On occasion, a provider may discover a notifiable safety incident that happened some time ago, or one that relates to care that was delivered by another provider. The provider that discovers the incident should work with others who are responsible for notifying the relevant person of the incident.”
Important things you may not realise

- (For NHS bodies) Applies to where incident “could” result in harm – it does not need to be actual or proven
- Applies to incidents discovered as result of research / case note reviews
- No option not to tell because it “may not be in the patient’s interests”
- Patient/family should be told about sources of INDEPENDENT & SPECIALIST help eg AvMA
What about individuals?

- CQC will expect organisation to discipline / refer individuals to regulators if they prevent the organisation from complying (eg if individuals cover up)
- The health professional regulators should be more proactive in promoting the duty and more robust in enforcing it
Critical to success

- Awareness and training, training, training
- Consistency across all healthcare
- Clear CQC guidance
- Clear GMC & NMC guidance
- More Robust approach to regulation
Practical steps to take now:

- Raise awareness of *Being Open/ CQC guidance*
- *Train staff (we can help)*
- *Audit incidents, complaints and claims (we can help)*
- *Take disciplinary action where appropriate*
- *Regulators to take firm and consistent stance*
The biggest ever breakthrough in patients’ rights & patient safety?

SUPPORT

ROBBIE'S LAW
Thank you! Any questions?

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