BRIEFING

Duty of candour – review of threshold

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About the Health Foundation

The Health Foundation is an independent charity working to improve the quality of healthcare in the UK.

We are here to support people working in healthcare practice and policy to make lasting improvements to health services.

We carry out research and in-depth policy analysis, fund improvement programmes in the NHS, support and develop leaders and share evidence to encourage wider change.

Our view

Being open with patients when something goes wrong with their care is clearly the right thing to do. There is a persuasive evidence base to support openness in such circumstances, and it is referenced in Briefing for the Duty of Candour Threshold Review Group: Review of definitions.

The purpose of the Threshold Review, however, is not to debate whether or not this should be done, but rather the circumstances in which it should be enforced by law. Specifically, should the threshold to 'trigger' the statutory duty of candour stop at the most serious incidents, or be lowered to include instances of moderate harm?

We believe that, in order to be effective, there are some clear principles that ought to be followed when developing a threshold for the duty of candour:

1. **Be clear**. The introduction of the duty of candour should be accompanied with very clear definitions of degrees of harm, examples to illustrate them and guidance to support health professionals to understand whether the harm is attributable to the care they provided. The accompanying guidance must also be clear about whether there is an automatic push of information, or whether it is in response to a request from a patient or family member (in those circumstances where a harm or near miss isn't immediately obvious to the patient).

2. **Be consistent**. Efforts in this area will be undermined by having conflicting guidance. We note that there currently exists a contractual duty of candour which sets the bar at

moderate harm, and the NHS Constitution which pledges to patients that they are told about *any harm* that is caused to them. Wherever the bar is set, it should be set to the same level across all the relevant guidance. However we would argue that *any harm* would be prohibitively difficult to define, given that there is also a subjective element to what people experience as harm.

3. **Be proportionate**. The principles and process of openness are well articulated in the existing NPSA *Being Open* guidance, produced in 2005 and later developed into a patient safety alert. We would support the widespread implementation of this guidance, but also recognise that it must be supported by significant training and resource to make it effective. However, there is evidence (below) that the costs of this could be offset by the reduction in claims and litigation costs as a result of disclosure programmes:

   A study at the University of Michigan Health Service showed that their damages payments per case reduced by 47 per cent and the average settlement time for claims reduced from 20 months to six months following the introduction of an apology and disclosure programme in 2001.

We also think it would be helpful if the review made reference to the typology of patient harm developed by Charles Vincent and colleagues in their report *The Measurement and Monitor of Patient Safety.* This typology illustrates the many ways in which people can be harmed as a result of the care they receive (or didn't receive):

- Treatment-specific harm e.g. adverse drug reactions
- Harm due to over-treatment e.g. overuse of antibiotics leading to *Clostridium difficile*
- General harm from healthcare e.g. falls
- Harm due to failure to provide appropriate treatment e.g. failure to provide rapid and effective treatment for myocardial infarction
- Harm resulting from delayed or inadequate diagnosis e.g. misdiagnosis of cancer by primary care doctor
- Psychological harm and feeling unsafe e.g. clinical depression following mastectomy.

A debate about what constitutes severe or moderate harm seems somewhat tangential, given that the consequences of moderate harm are clearly still very serious for the person concerned. Being Open defines moderate harm as a patient safety incident that 'resulted in a moderate increase in treatment'. This can include a return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or even transfer to intensive care as a result of the incident. It is therefore important to see the introduction of any duty of candour as part of a much wider, and more ambitious, suite of activities to improve openness in the NHS.

These activities should include a greater emphasis on seeking genuinely informed consent such that patients are fully aware of the risks of intervention – this will help to create a more proactive approach to safety management across the NHS. It must also include further work to create the right safety culture within organisations, where people feel able to surface safety issues with their colleagues.

Setting the bar at any level may, if not part of this wider work, lead to a small number of individuals seeking to reclassify incidents in the hope of side-stepping the legislation. **It should therefore be the ambition for the NHS to create a culture where it becomes second nature for healthcare workers to share with patients, carers and families all relevant information about their care, good and bad, in a way that makes them genuine partners in their care**. The thoughtful implementation of a duty of candour is a necessary but not sufficient first step towards achieving this

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