Department of Health consultation on Implementing a ‘Duty of Candour’; a new contractual requirement on providers

1. I write with regard to the Department of Health consultation on Implementing a ‘Duty of Candour’.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 44,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

3. The College welcomes the opportunity to respond to this consultation. From the start, we must stress that the College is vitally aware of the importance of openness, and will be fully supportive of any measures that improve patient satisfaction and patient safety through openness without impinging on other aspects of service quality. As stated repeatedly in the consultation document, it is right that when an incident has occurred in any NHS organisation which may have caused harm to patients a prompt apology should be issued by those responsible. Our contributors are agreed on this – but there is lively debate as to the most reasonable approach to ensuring it.
4. Our own document ‘Good Medical Practice for General Practitioners’ clearly sets out the behaviour expected of GPs in this area:-

‘The exemplary GP:
• contacts the patient soon after it is apparent that a mishap or mistake has occurred
• apologises for him or herself or for the practice staff
• tells the patient what has happened and, where possible, how it can be put right
• co-operates with any investigation arising from a complaint, and when appropriate instigates changes to prevent any recurrence
• tries to maintain a relationship with the patient or family when a mishap or mistake has occurred; if the relationship is irretrievably harmed handles this professionally and ensures appropriate handover of care to another doctor
• feeds back to the patient or family any action taken to prevent similar mishaps or mistakes in future.’

5. We strongly believe that professional duties, rather than legal or contractual obligations are the most powerful tools to ensure openness. We accept that these have not always been sufficient to prevent failures of openness and patient safety, but it is not clear, and certainly not proven, that the proposed measures will be any more effective.

6. What is not touched on in this consultation is the need to support those who expose organisational failings. It may be argued that the potential imposition of contractual and/or financial penalties may place potential whistleblowers in an even more invidious position than currently. We responded earlier this year to the Department of Health’s consultation on the NHS Constitution and Whistleblowing. In this we argued for:

    i. a legal responsibility on the management [of NHS organisations] to encourage staff to raise concerns and investigate them… this should have a positive impact on delivery of care at NHS organisations.

---


2 RCGP, Response to Department of Health consultation: ‘The NHS Constitution and Whistleblowing’ (2011)
ii. that there should be a responsibility on NHS professionals to raise concerns rather than an expectation. It is very important that there is a facilitative culture to enable them to fulfil their responsibility.

iii. NHS professionals should be receiving a high quality of training and development at all levels requiring them to understand their duty and responsibility to report concerns and act upon them. These duties and responsibilities already exist through their regulatory bodies etc and they should be reminded of these.

7. We have concerns, therefore, at potential unintended consequences of the current proposals – that they may actually impede development of a culture of openness, work which, thanks to the actions of professional bodies and organisations such as the NPSA, has made progress in recent years.

8. Another potential concern that is not considered is the situation where a disclosure/apology may be considered to be against the interest of a patient in terms of their pathway to recovery – would such a circumstance be exempted from the duty of candour?

9. We would also be wary of the claim that this should not result in any increase in litigation: our own medico-legal expert suggests that we should anticipate increased legal involvement, either through an increase in patient claims, claims for wrongful dismissal or mistreatment of whistleblowers, or contractual disputes with providers on whom penalties have been applied. We fully agree that an apology is not same as admission of negligence, but the published document should acknowledge that the approach taken may result in extra litigation. Any legal challenge results in clinicians (in their practice role or as commissioners) being distracted from their work in patient care, which of course risks increasing costs, and this is not fully accounted for in the impact assessment document provided. A commitment to ongoing evaluation of what happens with some specified guidance on factors that you think will minimise litigation would be helpful if set out clearly in the final document.

10. We have provided answers to specific questions from the consultation below:

1. **Do you think the contractual mechanism described here including the requirement for a declaration or commitment on openness, provides an effective mechanism for requiring openness?**

   Insufficient evidence is provided to demonstrate that a contractual mechanism will be any more effective than a system of professional obligations in encouraging openness.
As discussed above, it is quite possible that the contractual approach will inhibit the development of a culture of openness, and it is our view that there may well be significant hidden costs.

That said, the specific contractual approach taken appears reasonable for the most part, within the context of the NHS reforms. It is clear, from a number of high-profile failings in patient safety, that there does need to be more effective oversight of foundation trusts and other providers. Basing the approach on a public declaration by providers is a potentially useful device – serving a double purpose in both obligating providers and raising patient awareness at the same time.

There may be unintended consequences in the volume of additional bureaucracy that GPs and other clinicians may become involved in, which, as discussed above, will be increased further in the case of legal proceedings.

Conversely, the fact that this mechanism is only intended to apply where moderate harm or worse has occurred, whilst practical from the point of view of resources, means that this approach will do little to tackle the great majority of mistakes, where little or no harm may have actually occurred but which it would nonetheless be desirable to rectify and learn from.

2. Do you think there should be a range of consequences available for use depending on circumstances?
Certainly it is appropriate to have a range of consequences available. If commissioners were forced to resort to financial penalties in the first instance and for every transgression, it could prove very difficult to establish the strong, collaborative relationships between commissioners and providers that will ultimately ensure quality. The system will require some locally negotiated discretion, and agreement on appropriate boundaries – for example between situations where there have been multiple instances of moderate harm as against where there has been a single severe incident.

The emphasis must always remain on incentivising the identification and addressing of patient safety issues, rather than on a regime that is punitive or open to abuse by a patient (or doctor) with an ‘axe to grind’.

3. Do you have any suggestions for what the consequences should be – either as a range or as a single consequence?
We would agree with the consequences set out in the consultation – provided, as above, that there is room for discretion.

4. Should the level of escalation include suspension / termination of the contract?
Ultimately, yes, this would be a necessary provision – though one should expect, where failures of openness were occurring on this sort of scale, that this represented more widely a failure of care, and the organisation would be likely to be subject to sanctions anyway.

By definition this sanction would need to be used sparingly – it would be disastrous if the threat of contract termination contributed to a culture of fear in NHS providers and inhibited the openness that it was intended to encourage.

5. Do you think a requirement should be placed on primary care contractors and if so how might this be achieved?
Some of our commentators worry that applying this kind of requirement on GPs and other primary care contractors will have an inhibiting effect on patient care – that either GPs will become too afraid to refer or will spend disproportionate amounts of time reviewing discharge letters. Moreover, the worry is that the cost of this, in terms of both time and money, will fall on those who are most diligent, rather than on those more likely to be at fault.

On the other hand, it would clearly be difficult for GPs, as practitioners and commissioners, to be enforcing these rules on other healthcare providers whilst not being subject to them themselves. It is clearly quite possible that incidents requiring greater candour will occur in primary care settings. Ultimately, this is a question of the GP contract, and we are not in a position to comment.

6. Are these requirements reasonable and clear, including the 5 working day deadline?
The requirements are clear, but the five day deadline proposed, whilst probably seeming reasonable to patients, may well not be practical in many cases, particularly for smaller organisations without dedicated resources; it may lead to organisations, despite their sincere best efforts, being punished for failing on what is effectively a technicality.

7. Is there anything that should be included that isn’t?
Perhaps the proposal would benefit for careful specification of which kinds of organisations would be covered, given the current diversification of providers of NHS services.

8. Do clinicians, including GPs, feel able to assist their patients in identifying cases where there has been a failure to be open, and then either supporting their patient in raising these concerns, or simply referring the concern to the commissioner to investigate?

GPs often do this already, and not only will raise it directly with the hospital trust management but will often write to their LMC to raise complaints about the way a service works against the best interests of patients. There does need to be better patient support through complaints procedures, however.

9. What support and advice do clinicians feel would assist them in this?

Clinicians would benefit from properly thought out guidance and study materials to ensure that they are clear in their duties in this area – as well as better liaison between patient groups such as local HealthWatch and LMCs and CCGs, to ensure all understand local processes and cascade this learning at practice level.

If, as feared, this approach does generate significant additional workload and resource issues for GPs and others, there will be a need for ringfenced time and resources. We are concerned that the consultation underestimates this possibility, particularly at a time when the workforce is already experiencing shortage and is under significant new strains.

10. What additional support and advice would assist patients in raising concerns that could be made available through Local HealthWatch services?

Many patients will not be aware of Local HealthWatch – the emphasis should be on general practice as by far the most likely first point of contact for advice.

11. Does a ‘road map’ or ‘flowchart’ of ‘What To Do When Things Go Wrong’ sound like a useful tool for patients?

Yes, some kind of diagrammatic representation of the system, so long as it corresponds with reality, would be useful. It is noted that at present there is a tendency for patients to be advised by some patient organisations to make complaints in all directions at once – to the ombudsman, the PCT, the GMC, their MP and their GP. In practice this will slow processes and does not encourage prioritisation – a situation which a flowchart approach may improve.
One suggestion is that the flowchart could be localised (ie with specific local contacts) and could itself form part of the obligation to publish a declaration of openness – i.e. providers obligated to publish an up-to-date ‘when things go wrong’ chart.

12. Are there any equalities issues with this proposal? Will any groups be at a disadvantage and therefore less likely to receive openness?

Yes there are clear equalities issues (though not more so than under current or other provisions). Groups likely to be at a disadvantage include:-

- Those not registered with a GP, such as, frequently, the homeless, new immigrants and travellers. These groups will lack a clear route to advocacy under this system.
- Those with English not as a first language, with reduced literacy or learning disabilities – since the issues involved in requesting openness are complex and, with the best intentions possible, unlikely to be free of jargon and legal language.

Predictably, those most likely to make use of the proposed system are those with the education, time and resources to commit to it, not necessarily those with the greatest need. It will be another duty for CCGs (and GPs) to try to mitigate this effect.

13. Are the expectations on Commissioners clear and reasonable?

The expectations are clear, but they may not be reasonable, or realistic. The document claims that clinicians are not being asked to police system. But this is precisely what is being proposed, whether it is clinicians as practitioners or as members of CCGs who are being asked to do it. If CCGs in particular do not have sufficient resources to fulfil these functions they may be placed under intolerable strain, which will clear not be beneficial for patient care.

14. Should Commissioners be expected to do anything else?

No.

15. Are the public reporting requirements clear and reasonable?

Yes, though there is a danger of these being applied too mechanically and failing to be of use.

11. In summary, we are fully supportive of measures to encourage openness, but remain unconvinced that contractual obligations with implied penalties are the most likely to succeed. We are concerned that, without measures to support whistleblowers and encourage a culture of openness, the stated approach may actually inhibit openness.
12. The specific form of duty of candour discussed in the consultation is reasonable, but we would urge the Department of Health to consider again possible unintended consequences. In particular, we feel that the potential for considerable additional burdens on GPs, both as practitioners and as commissioners, is significantly underestimated, and may cause us to question whether clinical commissioning is being under-resourced.

13. We received a range of comments from our contributors, reflecting our members’ understanding of the importance of ensuring patient safety and the reasonableness of a culture of openness, but also their concern to find an equable and effective way forward. It is clear that NHS organisations are not always as open as they should be, and that this can cause harm to patients. GPs will certainly wish to play their part in any measures to improve this situation.

14. We gratefully acknowledge the contributions of members of our Ethics Committee, Centre for Commissioning and Patient Partnership Group, amongst others, in formulating this response.

Yours sincerely

Professor Amanda Howe MA Med MD FRCGP
Honorary Secretary of Council