RESPONSE TO PROFESSIONAL STANDARDS AUTHORITY CONSULTATION:

"ENCOURAGING CANDOUR"

Introduction

Action against Medical Accidents (AvMA) is the independent UK charity for patient safety and justice. Our policy priorities are informed from the experience of people who we support following things going wrong and causing harm in healthcare ("medical accidents"). We support around 3,500 people a year through our helpline and more intensive casework and inquest support service. We also work closely with the health professions, healthcare providers, regulators and government departments to improve patient safety and the way that the system responds to patients and families following a medical accident. Over our thirty years' experience of working in this area, the biggest and clearest priority has consistently been the need for openness and honesty with patients and families. In our experience, intolerable distress and damage is often needlessly caused to patients or their families as a result of a failure to be open and honest. Not only is being open and honest in these circumstances a moral and ethical imperative – it is essential for patient safety that there is insight and acceptance of when things have gone wrong and lessons learnt to help prevent re-occurrence. Some of the best health professionals we know are those who have learnt from their own mistakes.

AvMA have led the campaign for a Duty of Candour for over a decade and advised Robert Francis QC before he made his recommendations. We firmly believe that if we are successful in creating a much more open and honest culture in healthcare it will potentially be the biggest advance in patient safety as well as patients' rights in history. However, this will require a whole system approach which makes any lack of candour in these circumstances unequivocally intolerable, and which educates and supports health professionals in doing the right thing.

ANSWERS TO CONSULTATION QUESTIONS

1. **In your view, are all the regulators we oversee effective at encouraging the professionals they regulate to be candid when something goes wrong?**

No. Whilst most if not all of the regulators have a section of their code of practice which exhorts candour when things go wrong, we can see little evidence of any of the regulators going out of their way to promote this duty or to root out and take action against those health professionals who are in breach of it. Our enquiries with some of the regulators have so far revealed that information on revelations or allegations of a breach of this element of the code is not even systematically collected.

A judicial review challenge which AvMA made in 2009 to a GMC decision not even to investigate serious and well evidenced allegations of attempted cover ups by doctors in the case of Robbie Powell is very illuminating about the priority which that regulator attached to candour, at least at that time. The GMC refused to accept that it was sufficiently in the public interest to investigate these

doctors and that they were wrong not to use their discretion to waive their “five year rule” in spite of representations from AvMA, the family, and even the Health Board involved. This was a hammer blow to public confidence in the GMC’s commitment to enforcing the professional duty of candour. Indeed, it implied that the more successful a doctor is in covering up an incident (i.e. if a cover up is successful for more than five years) the more doctors are likely to escape investigation, leave alone sanctions. There has never been any insight shown by the GMC that it got its decision wrong. How many regulators would take the same stance? Public confidence has not been helped by the fact that the Professional Standards Authority (then the CHRE) did not challenge the decision itself and have to date failed to condemn such a blatant failure to regulate a professional duty of candour appropriately. It would help public confidence that a professional duty of candour will be upheld if the PSA and the regulators themselves made it clear that such a decision could not happen again, or would not go unchallenged.

2. **What could the regulators do differently to encourage the professionals they regulate to be more candid/open/honest about treatment or care that has gone wrong or incidents that have caused harm or nearly caused harm?** For example are there any improvements you think should be made to

a) Their codes of practice and how they support professionals to be open

Each code of practice should be reviewed to check that the wording with regard to openness and honesty with patients is sufficiently clear and consistent. It should make clear the importance of this element of the code. For example it should be given prominence within the code itself and should make clear that evidence of a failure to abide by this element of the code WILL (as opposed to ‘may’) result in investigation by the regulator and sanctions being applied if found to be the case.

We strongly recommend that regulators work with AvMA and others on an awareness and education campaign not only to get across the importance of this element of the code, but also to give health professionals guidance support and training to do the right thing. This should draw on real patient/family experience to get the message across about the effects of a lack of openness on patients and families; the experience of health professionals who have had to open up about their own mistakes; patient safety implications/learning from incidents; the existing ‘Being Open’ guidance and other resources to develop skills/confidence in open disclosure.

Careful consideration also needs to be given to the provision of appropriate support to health professionals following a patient safety incident and following disclosure about a patient safety incident. Healthcare professionals can be faced with particular challenges not least from management or their peers when they have been open about incidents. They need to be supported and protected and bullying and persecution of ‘whistleblowers’ outlawed and severely dealt with if it does occur.

b) Their fitness to practise/disciplinary investigation and adjudication processes

- Where there is evidence suggestive of a breach of this part of the code there should always be an investigation. No time bar or ‘five year rule’ should apply.

- Where it is found that the code has been breached serious sanctions should be applied. Unless there are truly exceptional extenuating circumstances this should usually mean a striking off
- Regulators should be on the lookout in the course of any investigation of a health professional for a breach of this part of the code (even if not cited in the original allegations). These should be added to the 'charges' made against the health professional
- Regulators should systematically record information on allegations of breaches, investigations of breaches, findings and sanctions re breaches of this part of their code
- Cases involving sanctions applied for breach of this part of the code should be widely promoted as an example and deterrent for others
- There needs to be a feedback loop to local systems of clinical governance about any breaches of the Duty of Candour by health professionals as this may have wider implications.

c) How their education standards and processes encourage education providers to satisfactorily prepare new professionals to be candid

Training in Being Open should be part of the core curriculum for all health professionals. AvMA would be happy to help with this building on work we have already done with some education providers.

d) How their registration and registration renewal processes work.

Any evidence of failure to abide by this part of the code that comes to light should be investigated and if found proven should, except in exceptional circumstances, result in registration or re-registration being refused.

Appraisals and the revalidation process should be used to check on this as well as other aspects of health professionals attitudes and practice. Particular regard should be given to complaints and claims about health professionals and how honest/candid the responses to the incident behind them and subsequently have been.

3. **What good practice is there in this area, either from overseas or here in the UK, which we could learn from?**

There is evidence of good practice in New Zealand, where the Ombudsman regulates a duty of candour. However, there is an abundance of experience and expertise already existing within the UK that can be drawn upon. The Being Open guidance produced by the NPSA is as good as anything that exists internationally.

4. **Are you aware of any reasons why a duty of candour on professionals may benefit or disadvantage patients, people who use social care services, carers or professionals differently depending on their age, gender, disability status, transgender status, ethnicity, nationality, sexual orientation, marital or civil partnership status, religion or belief?**

No.

AvMA August 2013