RCN response to
Implementing a ‘Duty of Candour’;
a new contractual requirement on providers

Introduction
With a membership of over 400,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

Background
The RCN is supportive of the Government’s desire, to ensure that the NHS;

‘admit[s] to patient safety incidents, apologise[s] to those affected, and ensure[s] that lessons are learnt to prevent them from being repeated’

People in receipt of healthcare should be comfortable in the expectation that the healthcare professional treating or caring for them is suitably trained and practiced in providing their treatment and that where necessary will advise them of the risks as well as the benefits of any recommended treatment.

However, we are acutely aware that practicing modern day healthcare can be both dangerous and inexact. Too often errors occur not because of negligence, but because of unknowns. In addition modern healthcare is practised in a system that is for the most part regularised and standardised in diagnosis, practice and treatment, all of which throw unexpected outcomes or errors into stark relief.

Against and because of this background, the RCN supports greater openness by healthcare professionals when things go wrong; a position which is in keeping with the duties imposed on both nurses and doctors by their respective regulatory codes.

We believe that such a stance is right for two different, but mutually compatible reasons. Firstly, and most obviously there is a moral responsibility to inform patients, and their families and carers, when a treatment results in an unforeseen outcome. This is especially vital when an error is of a harmful nature; not least in order that the patient may be given the appropriate remedial care.
Secondly, and equally as important though less often as considered, it that it is only by acknowledging when errors have occurred that healthcare professionals are able to improve their practice or that of their wider profession, and their employing organisations are able to undertake any necessary systemic reviews, since most errors are systemic rather than solely the fault of an individual practitioner.

It is from this later perspective that we respond to this consultation, whilst acknowledging fully the imperative for improvement on the status quo provided by the former.

**General Response**

Whilst we are supportive of the Department’s intentions, we do not believe that the proposed changes will fundamentally achieve the outcome that we all desire, that of ensuring, so far as is reasonable practicable, that all treatment errors are identified and notified to patients, or their families or carers; and that changes are made to clinical practice in order that such situations do not occur in the future.

Unfortunately the culture that exists within and across the NHS, as identified through the Francis Reviews and the work undertaken by the NMC in developing its code for raising and escalating concerns, too often militates against staff reporting where incidents occur, or errors are made. Additionally, too many NHS systems work to compound this cultural rejection of reporting, as evidenced by our recent survey which showed that many nurses are fearful of reporting when things go wrong, for fear of being blamed or ‘scape-goated’.

With those concerns in mind, we are keen to work with the Department and other interested groups, and especially patient and carer organisations, to see where common agreement can be found to ensure that progress is made in both reducing errors and accidents, and that where they do occur, there is openness, honesty, and learning for improvement.

**Specific Points**

- We do not feel that the proposed contractual duty of candour for healthcare providers, expressed primarily via a ‘declamatory annual statement’, will do anything to increase the openness and transparency of healthcare provider organisations in the event of patient safety incidents. Indeed we believe that it could well be devalued if patients and staff see that it is merely a ‘tokenistic’ gesture, which we believe it will become without adequate support for changes in the cultures and systems that exist across the NHS with regard to reporting errors and raising concerns.

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We are further concerned that the introduction of financial penalties into any reporting system is likely to reduce the reporting of such incidents, or even increase the likelihood of blame being apportioned to individuals, which will in our opinion militate against the important need to ensure that lessons are learnt across healthcare systems.

We do feel that some form of agreed procedure, to be required across all healthcare providers, would be of great benefit, and welcome the proposal for a structured approach to the investigation and reporting of incidents, as set out in section five of the consultation document.

We are also supportive of the development of a clear and simple roadmap, which can be used by patients, carers and families, in the event of wanting to raise a concern or lodge a complaint. We feel that this would best be developed through the Department of Health’s relationships with patient organisations, and with the support of professional bodies such as the royal colleges.

However, we are unsure of the viability of imposing a universal target of 5 working days for the reporting of adverse incidents. This may well be a worthy objective, however it may not be practical in complex cases, and so we would welcome further discussion of this proposal, especially with representatives of healthcare provider bodies, with a view to obtaining a consensually agreed timeframe which would be both manageable and in keeping with the need to be seen to be responding in a timely manner.

Both the ongoing Francis Inquiry and the changes that have already taken place in advance of the passage of the Health and Social Care Bill will have a dramatic impact on the structure and nature of the English NHS; not least in consequence of the loss of the National Patient Safety Agency. As such, the RCN feels that it would benefit the Government to give more thought as to how the ‘new’ system, premised on the commissioning of services being undertaken primarily by clinicians, can best incorporate the need to be frank about errors and mishaps, and most importantly reducing their occurrence.

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