National Voices

People shaping health
and social care

Response to the Department of Health Consultation 'Introducing the statutory duty of candour'

April 2014

Summary

Having campaigned consistently for a statutory duty of candour that covers the range of harms that are significant for patients, National Voices strongly welcomes the draft regulations to put this into practice.

Two areas of concern to us remain to be addressed:

1. To ensure that safety incidents that are likely to have caused harm – although that harm may not yet be apparent – are included in the definition of a notifiable incident.

2. To ensure that harmful omissions of care and treatment – failures to do something rather than doing the wrong thing – are included under the regulations.

In our view the first should result in an amendment to the regulations, while the second can be managed through the guidance to be produced by the Care Quality Commission.

About National Voices

National Voices is the national coalition of health and social care charities in England. We work together to strengthen the voice of patients, service users, carers, their families and the voluntary organisations that work for them.

Since 2010 we have campaigned alongside one of our member organisations, AvMA, and other allies to secure a statutory duty of candour. Most recently we gave evidence to the Dalton Williams Review.

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Response to the Consultation Questions

In this response we intend to answer only the two questions relating to the 'threshold' of the duty (Qs 1 and 2). Within this we will make specific comments on the drafting of definitions in the proposed regulations.

1. *Do you have any comments on the Duty of Candour harm threshold chosen for healthcare?*
2. *Do you have any comments on the Duty of Candour harm threshold chosen for adult social care?*

National Voices wishes strongly to welcome the government's decision to implement the recommendation of the Dalton Williams Review, that the threshold should be set to cover all incidents of harm that are significant from the perspective of the person using services. This ensures in particular that the duty will cover incidents that are currently classed as 'moderate' but which are significant to people and their families.

We also welcome the review by TLAP of the implications of the duty for social care, and the government's decision on setting the threshold at a similar and compatible level.

National Voices wishes to raise two remaining issues of concern, which we believe can be addressed by the government and the regulator.

Future harm resulting from a notifiable incident

The first issue is that, in the current drafting, incidents in which harm is *likely* to have been caused, but the results of that harm have *yet to appear*, may not be covered by the duty.

The draft regulations at 1(3) and (4) define notifiable safety incidents as those which '*appear to have resulted in*' [past tense] harm to the individual.

There is a risk that this would not cover, for example, incidents in maternity or postnatal care that are likely to cause disability or developmental delay to the child in later life.

We suggest that these clauses are amended by using a suitable qualifying phrase to cover likely future harm, for example:

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1(3) "In relation to the provision of health care services, "notifiable safety incident" means a safety incident that appears to have resulted in, *or on the basis of recognised evidence is likely to result in –*'

1(4)(a) 'appears to have resulted in, *or on the basis of recognised evidence is likely to result in –*'

Culpable omissions

The second issue is that harm to the individual may result from omissions to the care or treatment provided.

For example, in healthcare, this could be a failure to diagnose correctly at the right stage (misdiagnosis or delayed diagnosis).

In our view the provider should be under a duty to inform the person where such an omission is later discovered, and to explain what the potential consequences may be.

We suggest that the government should instruct the regulator, the Care Quality Commission, to include cases of omissions within the guidance it publishes for providers.

For further information

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