Logo

Description automatically generated A picture containing text

Description automatically generated ** **

**Response to the Welsh Government consultation on The Duty of Candour.**

The Royal College of Speech and Language Therapists (RCSLT), the Charted Society of Physiotherapists (CSP), The Royal College of Podiatry (RCP) and the Royal College of Occupational Therapists (RCOT) are responding jointly to the consultation on the duty of candour, with the aim of drawing together key themes and points of agreement for the Welsh Government to consider. We welcome the opportunity to respond to the consultation and view that making candour a statutory requirement appropriately reflects the ethical imperative of telling the truth about harm and is a powerful signal for honesty.

**1. Types of harm**

1.1 We welcome the fact that definition of the types of harm that would trigger the organisational duty of candour are to be developed and informed through dialogue with health care professions, taking due recognition of the different context, nature and requirements in health care settings.

1.2 We feel that the levels of harm framework and case study examples (annex B and H) are helpful in considering whether or not the duty of candour has been triggered. However, the consultation document appears primarily focused on medical model / acute care services. Whilst we understand that it is not possible to capture every scenario within a case study, we do believe there is a need for much more clarity and extended examples – possibly collated centrally and shared over time to ensure consistent interpretation of definitions across Wales. This might take the form of a “Has anyone else reported or disclosed this sort of event before?” online list of examples.

1.3 Moreover, as the Regulations will mandate that particular actions be conducted when a particular harm threshold has been crossed, the definitions supporting each level of harm will need to be provided with very clear guidance. There may be a risk of underreport events in order to avoid candour disclosures. There will be many instances where an open culture is supported and encouraged, but in settings where the culture is still influenced by financial or other nonpatient focused targets, there is a risk that open reporting will not be encouraged within the organisation, and pressure may be placed on staff to act in accordance with this.

**2. Staff training and support**

2.1 We recognise the rationale of making distinctions between a regulatory duty of candour imposed on healthcare professionals through professional duties linked to candour which regulators are expected to establish and formulate, an obligation of candour imposed by law on healthcare providers and a contractual responsibility of candour imposed on those providing NHS services under the standard NHS contract. This does, however, raise concerns regarding how the overarching framework of candour will be presented as a coherent whole and be implemented in a proportionate and cogent way.

2.2 The need for a clear communications strategy is important to ensure that those involved in the provision of health care understand the distinction between these three facets of candour regulation and importantly, the correct mechanism is used at the correct time. We are concerned that in the context of complex professional cultures, the realities of delivering care in under-funded health systems together with poor employment structures, systems and management, that individuals will be at risk of referral to their professional regulator for breaches of candour obligations when the individual is part of a wider poor organisational culture. We would expect an individual who is employed to be referred to a regulator for a misconduct relating to candour only where there is clear evidence that the failing was directly attributable to an individual.

2.3 Duty of candour training should become a key element of mandatory training on induction and annually for staff in post. As staff will need to be released from normal duties to do the training, release time should be equitable across professions depending on level of training deemed necessary. So, for example allied health professions (AHPs) should enjoy the same CPD release time for this training as their medical and nursing colleagues. Appropriate cover for AHP duties must be equally “covered”. Initial costs to organisations (for training time, cover etc.) are likely to depend on numbers of staff requiring training and efficiency of organisation of this CPD. We as professional bodies would be willing to support development and dissemination of information on duty of candour and access to training to our members and to AHP colleagues.

2.4 We are very supportive of the unique feature of the Welsh statutory duty of candour which goes beyond training for staff, as it recognises the need to support healthcare staff by placing an obligation on a NHS body to provide staff who are involved in a notifiable adverse outcome with details of services or support available. There is evidence that effective debriefing and supporting staff provided at a local level can help mitigate the psychological distress that can often accompany patient safety incidents, particularly those associated with death or severe harm.[[1]](#footnote-1)

**3. Regulation and monitoring**

3.1 We understand that a primary aim of the duty of candour is to encourage better decision making and ultimately aims to deliver better outcomes for all people who access health services, thus the focus being on learning and improving and not on punitive sanctions when NHS bodies fall short in their application of their duty. Whilst we are in agreeance with these objectives, we are concerned, that in reality, any proposed duty would require health professionals to report events to their employer, who would then assume responsibility for informing the patient. Regardless of the ethical duties imposed by an individual’s professional code of practice, ultimately the employer will determine how the responsibility of the duty of candour is executed. Previous studies of complaints in hospitals found that despite individual staff members raising complaints in accordance with their codes of conduct, the management structures took no early action. This raises questions as to whether the duty will only fully be effective if there is resource and ability to effectively inspect and bring action against failing providers.

**Further information**

We would be happy to provide further information if this would be of interest. Please see below our contact details.

**Naila Noori (she/her), External Affairs Officer (Wales), Royal College of Speech and Language Therapists,** [**naila.noori@rcslt.org**](mailto:naila.noori@rcslt.org)

**Tess Saunders, Policy and Public Affairs Officer (Wales), Royal College of Podiatry,** [**Tess.Saunders@rcpod.org.uk**](mailto:Tess.Saunders@rcpod.org.uk)

**David Davies, Professional Practice Lead (Wales), Royal College of Occupational Therapists,** [**David.Davies@rcot.co.uk**](mailto:David.Davies@rcot.co.uk)

**Callum Higgins, Chartered Society of Physiotherapy, Public Affairs and Policy Manager (Wales),** [**higginsc@csp.org.uk**](mailto:higginsc@csp.org.uk)

1. <https://www.themdu.com/guidance-and-advice/guides/duty-of-candour-scotland> [↑](#footnote-ref-1)