# Law

## Duty of candour after Mid Staffordshire report

**Mid Staffordshire NHS Foundation Trust hospital** SWNS


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### The new regulation can only be considered as a part of the jigsaw of important transparency and patient safety reforms

A new duty of candour on NHS trusts arising from the 2012-13 Francis inquiry into patient care comes into force this Thursday.

The Francis Inquiry into patient care at Mid Staffordshire NHS Foundation Trust uncovered some appalling examples of patient care. It also heard that patients were not always offered a full and frank explanation by the NHS trust when things had gone wrong.

To tackle this problem, a statutory "duty of candour" was recommended by Sir Robert Francis, QC, and accepted by the health secretary, Jeremy Hunt.

The new duty, found in regulation 20 of the Health and Social Care Act 2008 (Regulated Activities), places a general





requirement on specified NHS providers to act in an "open and transparent way" with patients in relation to their care and treatment.

It also lays down specific requirements on NHS providers to take certain important steps once they become aware of a "notifiable safety incident".

These steps include notifying the patient affected as soon as reasonably practicable, providing him or her with a true account of all the facts known to the provider about the incident, and offering an apology.

The threshold for "notifiable safety incident" is likely to provoke debate among clinicians and lawyers. It means "any unintended or unexpected incident" that, in the reasonable opinion of a healthcare professional, could have, or appears to have, resulted in the patient's death or "severe harm, moderate harm or prolonged psychological harm" to the patient.

The threshold for "moderate harm" appears to be low, requiring at least "harm that requires a moderate increase in treatment", which is itself defined as "an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care)".

The General Medical Council and other professional regulators issued draft guidance for consultation on November 3 that (if adopted) will require registrants to be "open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress".

The presence of an individual professional obligation on individual healthcare professionals is likely to bolster the statutory duty of candour (which applies to trusts) by prompting professionals to comply with the statutory duty, even in marginal cases where the threshold for "moderate harm" may not have been crossed.

How often NHS trusts or healthcare professionals will be pursued under either regime remains to be seen. It is hoped that patients are already given open and honest accounts when mistakes are made in the overwhelming majority of cases.

However, the fact that a duty of candor now has a statutory footing should give patients added confidence that when something does goes wrong with their care treatment, they must be informed.

Even with a statutory duty of candour in place, it is likely that NHS Trusts and healthcare professionals who are bent on covering up their mistakes will usually only be exposed if healthcare professionals who discover mistakes are willing to speak out.

For this reason, the duty of candour can only be considered as one part of the jigsaw of important transparency and patient safety reforms being considered by the Department of Health. This includes a review of the whistleblowing provisions applying to the NHS, which are currently under review by Sir Robert Francis, QC.


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