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Dear Sirs

**Openness and honesty when things go wrong: the professional duty of candour**

The Association of Personal Injury Lawyers (APIL) was formed by claimant lawyers with a view to representing the interests of personal injury victims. The association is dedicated to campaigning for improvements in the law to enable injured people to gain full access to justice, and promote their interests in all relevant political issues. Our members comprise principally of practitioners who specialise in personal injury litigation and whose interests are predominantly on behalf of injured claimants. APIL currently has around 3,800 members in the UK and abroad who represent hundreds of thousands of injured people a year.

We welcome the opportunity to respond to the GMC and NMC's joint consultation on draft guidance on the professional duty of candour. Our views on the statutory duty of candour, recently introduced for NHS bodies, can be found in our response to the Department of Health consultation *Introducing the statutory duty of candour*.

We welcome the guidance as helping healthcare professionals to comply with the duty of candour, and thus improving openness and transparency. There must, however, be an accompanying culture change towards honesty and candour amongst staff. Looking at the guidance, there is a danger that the duty will simply become a tick box exercise, if the necessary culture change is not lead by those in charge. Those on the "front line", who are most likely to realise that a mistake has been made and therefore most likely to be required to comply with the new duty of candour, are also most likely to be junior doctors, and nurses. These people must be comfortable in knowing that they can and should speak up when something goes wrong – and this can only happen if a change in culture occurs alongside the duty and guidance.

Whilst most of this consultation is outside of our remit, focusing on the practical application of the guidance, we do have a number of comments to make, particularly on the issue of near misses.

**General comments**

We are concerned that the guidance should clearly reflect the requirements of the statutory duty of candour, contained within regulation 20 of the Health and Social Care (Regulated Activities) Regulations - particularly that where a "notifiable safety incident" has occurred and the health service body becomes aware of this, the patient should be alerted as soon as reasonably practicable. The duty kicks in when the healthcare professional becomes aware of the harm - so the person who apologises, therefore, will not necessarily be the person who made the mistake. The guidance must make this clear.

**Q 7 To what extent do you agree that patients should always be told about near misses?**

APIL does not believe that the duty of candour should be extended to near misses. APIL welcomes the harm threshold contained within regulation 20 of the Health and Social Care Act (Regulated Activities) Regulations 2014, which requires notification to the patient where there has been an adverse incident resulting in death, moderate to severe harm or prolonged psychological injury. This is a proportionate threshold, as it strikes the balance between providing the patient with an apology if something has happened to them, without requiring the doctors to divulge every "near miss". Telling the patient about every slight incident, even if there was no harm, may result in adverse effects on patients, causing them unnecessary worry and confusion, which will lead to a loss of confidence in their healthcare provider. This is not to say that near misses and slight incidents should not be taken seriously. We agree with the consultation that it is important that near misses are reported so that all healthcare professionals can learn from them and prevent harm to other patients – but this is a separate issue to the duty of candour.

The purpose of the new statutory duty is to increase openness between the service provider and user. This can be achieved without the need to cause unnecessary anxiety to the patient; and without overloading health and social care professionals with an unmanageable administrative burden. We do not believe that the duty of candour should be extended to include near misses, but instead – as is currently the case – professional judgement should be used when considering whether to inform patients about near misses, and learning materials and other guidance should be provided to help medical professionals make a

decision as to whether, in the circumstances, a patient should be told that a mistake has been made. This is the most beneficial approach as it will mean that patients are not needlessly upset or frightened through being informed of every near miss, and also the duty of candour is not unnecessarily burdensome. If the duty is not overbearing, health and social care professionals are likely to embrace a new culture of openness. This would hopefully lead to more openness and transparency as a whole, not just in those situations as required by the regulations.

We hope that our comments prove useful to you. If you have any queries about our response, please do not hesitate to contact us.

Yours faithfully

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