Jeremy Nolan Room 2E11 Quarry House Quarry Hill Leeds West Yorkshire LS2 7UE



24 April 2014

#### Dear Mr Nolan

## Introducing the statutory 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 over 4,000 members in the UK and abroad who represent hundreds of thousands of injured people a year.

APIL welcomes the proposals to introduce a statutory duty of candour to cover all health and social care providers registered with the Care Quality Commission (CQC). We are pleased that the proposed statutory duty will be wider reaching than the contractual duty of candour currently contained in NHS service contracts. A new statutory duty would ensure consistency, and encourage an open and transparent culture across all health and adult social care providers. APIL believes that the majority of those injured as a result of medical accidents frequently want nothing more than an explanation of what went wrong and why. They also want to know that lessons have been learned. The proposed statutory duty of candour would help to achieve this.

#### Harm threshold

The harm threshold of moderate to severe harm or death is welcome as a first step to improving candour. 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 to lose

confidence in their health care providers. This is not to say that near misses and slight incidents should not be taken seriously and addressed to ensure that they do not occur again, but this is a separate issue to the duty of candour contained within the draft regulations.

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 worry to the patient; and without overloading health and social care professionals with an unmanageable administrative burden. 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.

Further, the threshold is likely to be interpreted as broadly as possible by health and social care providers, because of the criminal sanctions available to the Care Quality Commission (CQC) should there be a breach of the statutory duty. In order to avoid possible sanctions, health and social care providers will ensure that "moderate harm" covers most harm that occurs.

# **Reporting requirements**

It is important that there is a compulsion on the duty holders to report accidents that result in moderate to severe harm or death, to the Care Quality Commission. The consultation document mentions that the CQC will normally be notified of the incidents that occur in NHS-funded care via reporting to the existing National Learning and Reporting System (NRLS). It is important that the CQC is notified in all cases, not just those involving NHS establishments. This will ensure that the CQC is fully informed when things go wrong, and plans can be put in place to prevent repeat incidents.

We also suggest that there should be provision in the Act that in the event of a death, the incident should also be reported to the Coroner.

### Guidance

We agree that the CQC should issue guidance alongside the regulations providing for a statutory duty of candour. It is important that service providers are clear as to their obligations under the regulations, and that a wider culture of openness and transparency is developed as a result.

We hope that our comments prove useful to you.

Yours sincerely

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Alice Warren

Legal Policy Officer

Association of Personal Injury Lawyers 3 Alder Court Rennie Hogg Road Nottingham NG2 1RX