

# Royal College of Psychiatrists Consultation Response

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**DATE: 31.01.12**

**RESPONSE OF:** THE ROYAL COLLEGE OF PSYCHIATRISTS

**RESPONSE TO: Duty of Candour**

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. This consultation is informed by the views of members of the College's Faculties of General and Community Psychiatry, Child and Adolescent Psychiatry, Old Age Psychiatry, Forensic Psychiatry and Learning Disability Psychiatry.

This consultation was approved by: Dr Ola Junaid-Associate Registrar

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## **Response to the Duty of Candour**

### **General comments**

We support this direction of travel, which is consistent with the recent NPSA policy 'Being Open'.

However, mechanisms will need to be drawn up to monitor whether organisations are being open, and some form of audit will be required.

The focus of the consultation is on events which cause demonstrable harm, and favours a focus on acts of commission (or omission) in the course of treatment. One of the problems for mental health services is that the harm can occur in a more subtle way, by failure to provide a service or intervention at all. This can be a failure of commissioners or Trusts to adequately provide services. While this may be tangential to the consultation, we wished to raise it as an important issue, as this category of harm is not adequately dealt with.

### **1. Do you think the contractual mechanism described here including the requirement for a declaration or commitment on openness, provides an effective mechanism for requiring openness?**

Yes it does, but the details do remain vague as it is difficult to see how it will be evidenced. Websites are now vast directories and it would be easy to have a sentence somewhere on a website which made little impact.

We are sceptical of the suggestion of a percentage of contract value. Larger providers have an increased risk of lack of openness and a greater financial penalty for each contravention. It may be preferable to make fixed penalties which could include financial and non-financial recompense.

It is very difficult to be precise around candour. According to the NPSA there are more than a million patient safety incidents every year across a massive spectrum of clinical care, with the vast majority leading to no great harm. Doctors are asked to be leaders and to manage risk; this requires the use of judgement, which includes an assessment of how much information to share and with whom. Too much information can be harmful and cause distress, unnecessary investigation or even lead to interventions that have side-effects worse than the original problem. Assessment of risk is entirely subjective, and a skill that professionals have to varying degrees depending on aptitude and experience.

The doctor-patient relationship has expressed and implied communications and sometimes a desire to be optimistic is strongly applied and a desire to be pessimistic counter-productive. If one told a family of the possible outcomes of treatment resistant schizophrenia, when their 16-year-old son presented with a first episode of psychosis, which may in fact have a good prognosis, then that would be cruel and may frighten unnecessarily and even cause actual harm.

A one-size-fits-all contractual mechanism could be damaging. Broad guidelines with sanctions for misleading and open dishonesty are important but reliance on human compassion and sound judgement in most cases is very important.

## **2. Do you think there should be a range of consequences available for use depending on circumstances?**

Yes. There are probably sufficient consequences available already, through the professional codes of practice and the NHS constitution. Presumably therefore there would potentially already be greater sanctions for more serious breaches. If more sanctions were introduced, it is not clear who would be responsible for enacting them.

### **3. Do you have suggestions for what the consequences should be either as a range or as a single consequence?**

There should be a range of financial penalties which are in line with the failure to meet other contractual arrangements, and proportionate to the fault.

Public opinion, however, will be increasingly important as a driver of business, so it would make sense for the provider to make public statements, perhaps including to its membership (for FTs), about the breach, the incident that led to the breach and what is being done to avoid similar breaches in future. Some of the more open consumer-focused sites could be given access to all breaches.

Encouraging leadership and training around the positive aspects of openness should be encouraged at all levels, including political and senior management. It is also important to discourage knee-jerk blaming and 'this will never happen again' statements.

We suggest that analysis of the long-term impact of positive encouragement and learning processes, versus scapegoating 'blame game' processes, would be very useful research, perhaps as part of the NHS service evaluation programme.

### **4. Should the level of escalation include suspension / termination of the contract?**

Yes, if there is evidence of dishonesty or fraudulent behaviour. However, this does partly depend on what "the contract" is. Is this referring to the contract between a commissioner and provider for the whole complement of services, or the contract relating to a particular sub-service? Presumably commissioners can choose to withdraw contracts for any number of reasons already, one of

which will be related to quality and governance. Does there need to be any other special mechanism? On the plus side, since commissioners can withdraw services anyway, perhaps this would just emphasise the degree of seriousness that the commissioner applies to candour?

While the contractual mechanism seems reasonable, subject to our comments above, we would suggest a range of consequences. Suspension or termination of a contract in response to persistent breaches may be necessary as a last resort. However, this raises a concern for us about what happens if there is no alternative provider for the service? We would suggest there is in such circumstances a need to consider other options – for example, could there be a health equivalent of the education model of a service being placed in ‘special measures’?

Generally, we would support the encouragement of a more developmental approach, given the need for continued cultural change.

## **5. Do you think a requirement should be placed on primary care contractors and if so, how might this be achieved?**

A relevant question might be to ask what is currently required of GPs and their practices with regard to incident reporting – how does the “Being open” guidance currently apply in primary care in terms of responsibility for actions? There may be mechanisms in the interim for bolstering up the impact of professional standards on openness.

There is an argument for the requirement being placed on all contractors, particularly as the demarcation between primary care and secondary care is less clear.

All providers and contractors should have quality as a cornerstone of their aspirations. This includes learning from mistakes/setbacks positively,

apologising swiftly where it is due, and correcting issues quickly. Focusing on consequences and punishments is found in almost all psychological research to encourage fearfulness, avoidance and self-protection. A focus on positive learning from experience and evolution should therefore be strongly encouraged.

**6. Are these requirements reasonable and clear, including the 5 working day deadline?**

These guidelines are clear and fall within currently accepted procedures. However, in the case of serious incidents the investigations can rarely be completed effectively in five working days. It would be helpful for individual incidents to be considered.

**7. Is there anything that should be included that isn't?**

Yes. This guidance should include near-miss data for events of potential moderate harm or worse. Evidence should be included to show how litigation costs would be reduced.

**8. Do clinicians, including GPs, feel able to assist their patients in identifying cases where there has been a failure to be open, and then either supporting their patient in raising these concerns, or simply referring the concern to the commissioner to investigate?**

There are existing whistleblowing policies that would probably be adequate for breaches of openness. There might be an argument for extending these internal policies to include a commissioner representative as one of the chain of people who could be informed of breaches.

It is not certain that clinicians would feel able to be completely open, as there could be fears about how their employing organisation could respond. There

needs to be some form of protection for whistleblowers as otherwise an additional burden could be placed on GP resources.

We would support GPs in whistleblowing but consider they should not be personally involved, as the tensions would arguably be too difficult to resolve.

**9. What support and advice do clinicians feel would assist them in this?**

There needs to be a clear expectation of non-prejudicial behaviour by the employer, so that clinicians feel supported. Linked to this is the need for confidentiality and support, as with whistleblowing policies. Administrative support would also need to be made available.

**10. What additional support and advice would assist patients in raising concerns that could be made available through Local HealthWatch services?**

PALS schemes seem to be effective in representing patient concerns and complaints; perhaps their role could be enhanced?

**11. Does a 'road map' or flowchart of 'what to do when things go wrong' sound like a useful tool for patients?**

Yes, we strongly support this, but it needs to be linked into existing complaints policies. It would be helpful if the different bodies to which patients/carers can complain could be included in the flowchart.

**12. Are there any equalities issues with this proposal? Will any groups be at a disadvantage and therefore less likely to receive openness?**

There are a number of equalities issues with this proposal. People without capacity, in particular people with dementia, learning disabilities and a small number of people with mental illness would be more likely to be at a disadvantage. Ethnic minority groups could also be disadvantaged both socially and through communication problems. It is important that there should be appropriate use of patient advocates and attorneys.

**13. Are the expectations on Commissioners clear and reasonable?**

Yes.

**14. Should commissioners be expected to do anything else?**

No comment.

**15. Are the public reporting requirements clear and reasonable?**

Yes.

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