Comments to the Health, Social Care and Sport Committee on the Health and Social Care (Quality and Engagement) (Wales) Bill

August 2019

1. Introduction

1.1 The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and the registration of people working in health and care. We are an independent body, accountable to the UK Parliament. More information about our work and the approach we take is available at www.professionalstandards.org.uk

1.2 As part of our work we:

- Oversee the nine health and care professional regulators and report annually to Parliament on their performance
- Accredit registers of healthcare practitioners working in occupations not regulated by law through the Accredited Registers programme
- Conduct research and advise the four UK governments on improvements in regulation
- Promote right-touch regulation and publish papers on regulatory policy and practice.

2. General comments

2.1 We welcome the opportunity to respond to the call for information by the Health, Social Care and Sport Committee as part of their scrutiny of the Health and Social Care (Quality and Engagement) (Wales) Bill. We previously provided comments to the Welsh government consultation on the proposals contained within the Bill.[1]

2.2 We are broadly supportive of the introduction of a statutory duty of candour for NHS providers in Wales. This will bring Wales into line with England and Scotland and ensure that healthcare organisations in Wales are committed to being open and honest with patients and their families when things go wrong.

2.3 However, it is important to ensure both that there is alignment as far as possible with the professional duty of candour which all of UK-wide health and care regulators are signed up to. It is also critical that legislation and associated regulations do not create additional complexity for professionals by creating different thresholds and procedures for complying with the duty of

[1] Professional Standards Authority, *Comments on the Welsh Government consultation 'Services fit for the future'*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/consultation-response/others-consultations/2017/professional-standards-authority-response---welsh-government-services-fit-for-the-future-consultation.pdf?sfvrsn=eee67320_4

candour across the UK. We know from our policy work and research that where compliance with standards and requirements is made too complex this can create a barrier to professionals doing the right thing.

2.4 It is also important to consider other ways to embed the duty of candour in organisations alongside legislation, through consideration of the wider barriers for professionals to speaking up and being open and honest. Whilst the duty of candour is distinct from processes to encourage raising of concerns or whistleblowing in certain cases, the barriers and enablers are similar. Evidence from England demonstrates that legislation alone is not sufficient, and that wider cultural change is required to ensure that practitioners feel supported to be open and honest with patients and their families and raise concerns when necessary.

2.5 We are also supportive of the intention to create a stronger public and patient voice in Wales and we recognise the Welsh Government's intention to address some of the challenges identified with the current system. However, we would not want to see the strengths of the current system of patient engagement through the Community Health Councils lost and it will be important to ensure that the new body is equipped with the powers to represent the patient voice effectively and independently.

2.6 We have outlined below some more detailed comments on some of the specific elements of the Bill, however we would be happy to provide any further information to the Committee if required.

3. Detailed comments

Duty of candour

3.1 We are very supportive of the proposals to introduce a statutory duty of candour for all health and social care providers in Wales. This will help to ensure a commitment to candour across the UK following the introduction of the statutory duty of candour in England in 2014 and Scotland in 2018. There is also the professional duty of candour which was introduced for registrants of the nine UK-wide health and care regulators in 2014 following the publication of a joint statement of commitment by eight of the nine regulators.[2]

3.2 However, we suggest that it might be helpful to give further consideration to the threshold for applying the duty of candour and how to ensure alignment across the UK if possible.

3.3 As currently drafted, the Bill states that the duty of candour will apply when a service user (to whom health care is being or has been provided) suffers an adverse outcome. An adverse outcome is defined as: 'if the user experiences, or if the circumstances are such that the user could experience, any unexpected or unintended harm that is **more than minimal'** (emphasis

[2] Joint statement from the Chief Executives of statutory regulators of healthcare professionals, *Openness and honesty - the professional duty of candour.* Available at: https://www.pharmacyregulation.org/sites/default/files/joint_statement_on_the_professional_duty_of_candour.pdf

added). The statement of policy intention provided to the Committee outlines that the definition of 'more than minimal' will be set out in guidance.

3.4 This appears to differ from the thresholds outlined for both the statutory duty of candour in England and the duty of candour in Scotland. In England the regulation refers to a 'notifiable safety incident' which could lead to the death of the service user (as a result of the incident rather than the natural course of the service user's illness or underlying condition) or 'severe harm, moderate harm or prolonged psychological harm to the service user.'[3] In Scotland the regulations refer to 'unintended or unexpected incidents' which result in certain specified outcomes.[4]

3.5 In our recent report looking at the progress made by the professional regulators in embedding the professional duty of candour, we heard from stakeholders that consistency in the application of thresholds in relation to the duty of candour was important in helping professionals to understand what is expected of them. This included consistency between professional regulators but also greater clarity on the inter-relationship between the professional and statutory duty of candour. Some respondents to the questionnaire we issued to inform the report noted that there was overlap between the professional and statutory duties and that this was sometimes confusing, or even frustrating, for professionals. [5]

3.6 We recognise that there may be other factors influencing decisions on how to define when the statutory duty of candour should apply in each country. However, as we stated in our response to the Scottish regulations, we suggest that it would improve clarity and understanding of the duty if a common threshold was in use across the UK.[6] Ideally this would include a common approach to the professional duty of candour and the statutory duties in each country.

3.7 In our response to the Welsh Government consultation on the introduction of the statutory duty in 2017 we highlighted that there has been some concern expressed in England that the duty of candour is not becoming embedded within services and not leading to cultural change. We also highlighted our disappointment that we have not seen the professional duty of candour reflected in the allegations drafted against the registrant or references to the duty of candour in panel determinations for the regulators we oversee.[7] There

[3] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 – the duty of candour. Available at: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour#full-regulation

[4] Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016, *Duty of candour procedure*. Available at: http://www.legislation.gov.uk/asp/2016/14/part/2/crossheading/duty-of-candour-procedure/enacted

[5] Professional Standards Authority 2019, *Telling patients the truth when something goes wrong - Evaluating the progress of professional regulators in embedding professionals' duty to be candid to patients.* Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/telling-patients-the-truth-when-something-goes-wrong---how-have-professional-regulators-encouraged-professionals-to-be-candid-to-patients.pdf?sfvrsn=100f7520_6

[6] Professional Standards Authority 2015, *Response to the Scottish Government consultation: Proposals to introduce a statutory duty of candour for health and social care services*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/consultation-response/others-consultations/2015/scottish-government-duty-of-candour.pdf?sfvrsn=75a57f20_9

[7] Ibid.

is further detail on progress made by the professional regulators in embedding candour in our recent report.[8]

3.8 The Authority provided advice for the Department of Health on implementing the professional duty of candour in 2013 and also carried out research in 2013 into candour, disclosure and openness, highlighting a number of barriers to health professionals doing the right thing[9]. These barriers can apply to reporting even extremely harmful and criminal behaviour. The report into the abuse and neglect of patients by staff at the Winterbourne View care home in Gloucestershire in 2011[10] shows that when people do speak up this has not always been acted upon by those with regulatory oversight and also demonstrates that those in positions of authority should not be able to claim ignorance as an excuse for failing to prevent abuse.

3.9 We would be very happy to contribute further information relating to our work on candour or provide any further input on how the Welsh Government can seek to embed the duty of candour in Wales.

Patient voice body

3.10 As noted, we are supportive of the intention to create a stronger public and patient voice in Wales. However, we note that the OECD in its 2016 report on health and care in Wales highlighted the important role of the Community Health Councils (CHCs) in engaging with patients and ensuring that the patient voice is heard alongside suggestions to increase clarity of functions and improve scrutiny of the NHS.[11] It is therefore important that the strengths of the current system of patient engagement through the Community Health Councils is not lost and that that the new body is equipped with the powers to represent the patient voice effectively and independently.

3.11 We note the comments from the Board of Community Health Councils regarding ways to ensure that a new patient voice body has the tools it needs to effectively represent the needs of health and social care users, including the importance of direct engagement with service users accessing care.[12] In our

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[8] Professional Standards Authority 2019, *Telling patients the truth when something goes wrong - Evaluating the progress of professional regulators in embedding professionals' duty to be candid to patients.* Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/telling-patients-the-truth-when-something-goes-wrong---how-have-professional-regulators-encouraged-professionals-to-be-candid-to-patients.pdf?sfvrsn=100f7520_6

[9] Professional Standards Authority 2013, *Candour, disclosure and openness - Learning from academic research to support advice to the Secretary of State*. [Online] Available at: http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/candour-disclosure-and-openness-2013.pdf?sfvrsn=6 [Accessed: 15/08/2017]

[10] Department of Health Review: Final Report*, Transforming care: A national response to Winterbourne View Hospital.* [Online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf [Accessed: 18/08/2017]

[11] OECD Reviews of Health Care Quality: United Kingdom 2016. [Online] Available at: http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/oecd-reviews-of-health-care-quality-united-kingdom-2016_9789264239487-en#.WcuSMTVry2w#page227 [Accessed: 29/09/2017]

[12] Community Health Councils respond to the publication of the Health and Social Care (Quality & Engagement) (Wales) Bill:

role representing the interests of patients in ensuring that health and care professional regulators protect the public, we have seen the importance and value of direct engagement with, and research with, members of the public and suggest that this should be a priority for any future patient voice body in Wales.

4. Further information

4.1 Please get in touch if you would like to discuss any aspect of this response in further detail. You can contact us at:

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