

## **Introducing the statutory duty of candour: A consultation on proposals to introduce a new CQC registration regulation**

Chartered Society of Physiotherapy  
Consultation response

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The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the UK's 52,000 chartered physiotherapists, physiotherapy students and support workers.

The CSP welcomes the opportunity to respond to the consultation on "Introducing the statutory duty of candour: A consultation on proposals to introduce a new CQC registration regulation"

<https://www.gov.uk/government/consultations/statutory-duty-of-candour-for-health-and-adult-social-care-providers>

The CSP plays a key role in ensuring high professional standards in the UK physiotherapy profession. It sets out clear expectations of members' professionalism through a Code of Professional Values and Behaviour <sup>1</sup> and Quality Assurance Standards.<sup>2</sup>

### **The contribution of physiotherapy**

Physiotherapy enables people to move and function as well as they can, maximising quality of life, physical and mental health and well-being. With a focus on quality and productivity, it puts meeting patient and population needs, and optimising clinical outcomes and the patient experience, at the centre of all it does.

As an adaptable, engaged workforce, physiotherapists have the skills to address healthcare priorities, meet individual needs, and to develop and deliver integrated services in clinically and cost-effective ways.

Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity. Physiotherapists work with

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<sup>1</sup> <http://www.csp.org.uk/professional-union/professionalism/csp-expectations-members/code-professional-values-behaviour>

<sup>2</sup> <http://www.csp.org.uk/publications/quality-assurance-standards>

children, those of working age and older people; across sectors; and in hospital, community and workplace settings. Physiotherapists facilitate early intervention, support self management and promote independence, and help prevent episodes of ill health and disability developing into chronic conditions. Physiotherapy supports people across a wide range of areas including musculoskeletal disorders (MSD); many long-term conditions, such as stroke, MS and Parkinson's disease; cardiac and respiratory rehabilitation; children's disabilities; cancer; women's health; continence; mental health; falls prevention.

Physiotherapy delivers high-quality, innovative services in accessible, responsive, timely ways. It is founded on an increasingly strong evidence base, an evolving scope of practice, clinical leadership and person-centred professionalism.

Physiotherapists come into direct contact with patients and are well placed to observe the nature of care that patients receive, and the CSP welcomes this opportunity to comment on the proposed introduction of a statutory duty of candour.

## **1. Do you have any comments on the duty of candour harm threshold chosen for healthcare?**

- 1.1 The Regulations will trigger a statutory requirement for organisational candour disclosure for '*all moderate harm, all severe harm, all deaths (by the incident not natural course of the disease) and all prolonged psychological harm*' which are reported either by internal reporting structures, or the wider NHS National Learning & Reporting System (NRLS). We support the broadening of the criteria to include moderate harm as we believe patients should be informed promptly and factually when events occur that harm patients that has lasting impact.
- 1.2 These definitions should apply to all healthcare settings, and all patients.
- 1.3 We do not support the proposal to have different reporting thresholds for candour reporting between healthcare and adult social care. Care must be taken not to discriminate against the levels of care a particular patient group can reasonably expect to receive. ALL patients, regardless of age or care setting should expect the same levels of candour disclosure regardless of setting.

## **2. Do you have any comments on the Duty of candour harm threshold chosen for adult social care?**

- 2.1 The Regulations will trigger a statutory requirement for organisational candour disclosure for '*all serious injuries, all deaths (by the incident not natural course of the disease), some moderate harm, some prolonged psychological harm*' are reported. We do not support the proposal to have different reporting thresholds for candour reporting between healthcare and adult social care.
- 2.2 We do not believe the argument that the healthcare definitions of harm as used by NRLS cannot be transferrable to social care settings. We understand that NRLS was developed for healthcare environments, but the landscape of care delivery has changed since NRLS was developed, and it is now strongly unpalatable to suggest that people receiving care in social care settings are not entitled to the same levels

of candour reporting as those in healthcare settings. We accept that social care settings do not have an equivalent to the NHS NRLS system and so the CQC notification definitions will be used. However, in this instance it appears that the NHS has developed a superior system of defining and recording notifications of harm, and this is a good opportunity to transfer the operation of a good system to another care setting. Simply using what is arguably an inferior definition system, without fully exploring the options for transferability of a better system, is at best a lost opportunity to transfer good examples of practice, and at worst an example of failing to properly consider and implement what is in the interests of *all* patients and service users.

- 2.3 We do not support the proposal to have different reporting thresholds for candour reporting between healthcare and adult social care. Care must be taken not to discriminate against the levels of care a particular patient group can reasonably expect to receive. ALL patients, regardless of age or care setting should expect the same levels of candour disclosure regardless of setting.
- 2.4 This discrimination is reinforced in the draft wording of the legislation where at Section 1(5) it clearly states that where a person receives both health and social care, in those contexts the higher (i.e. more open) level of candour disclosure is to apply. Moreover Section 1(3) gives a very short and clear two-point legal definition of a 'notifiable incident' for health care services, whereas for social care services at section 1(4) there is a long and detailed multi-point definition.

### **3. Do you agree with the requirements to be placed on service providers under the Duty of Candour?**

- 3.1 We recognise the logic of having a distinction between a) a statutory duty of candour placed on healthcare *providers* b) a regulatory duty of candour placed on healthcare *professionals* (by strengthened professional responsibilities relating to candour – which regulators are expected to develop and formulate) and c) the contractual duty of candour placed on those delivering NHS services under the *standard NHS contract*. However, this does raise concerns about how the overall framework of candour will be presented as a cohesive whole and be enforced in a proportionate and cohesive manner.
- 3.2 Moreover, there will need to be a clear communications strategy to ensure that all involved in the provision of health and social care understand the distinction between these three facets of candour regulation such that the correct mechanism is used at the correct time. In particular, where individuals are 'employed', these provisions for candour should not mean that an individual becomes a scapegoat for an organisation's wider failings in managing concerns and/or complaints with regards to openness and candour. Poor employment structures, systems and management may leave individuals at risk of referral to their professional regulator for breaches of candour obligations when the individual is part of a wider poor organisational culture. We would expect an individual who is employed to be referred to a regulator for a candour misdemeanour only when there is concurrent CQC action against the organisation for its failings as well, unless there was clear evidence that the failing was directly attributable to an individual.

- 3.3 Any proposed statutory duty on organisations would, in reality, require health professionals to report events to their employer, who would then assume responsibility for informing the patient. In other words, regardless of the ethical duties imposed by an individual's professional code of practice, it is the employer who will ultimately determine how that duty of candour is performed. Therefore there must be clear and explicit guidance provided for employers. Previous reviews of concerns in hospitals have identified that individual staff had raised concerns in accordance with their codes of conduct and yet no early action was taken by the management structures. These candour standards will only be effective if the CQC has the resources and ability to effectively inspect and bring action against failing providers. Whether the Regulations are enforceable will depend on an analysis of the interdependencies between other sources of 'candour' regulation. However, where these regulations do make explicit reference to the duties of CQC registered providers, then they will provide patients with one route for a concrete course of redress.
- 3.4 These Regulations will only be effective when there is a concurrent amendment to the terms of the NHS Indemnity scheme such that an early open apology is not automatically seen as an admission of liability for clinical negligence. Although sadly, mistakes can be a result of negligence in some cases, and patients must be clearly informed of the facts, it must be clearly recognised that in many health care interventions, an adverse outcome may occur even when the intervention is performed perfectly properly. Until such changes and/or clear guidance is given to organisations, regulators and individuals, the cultural changes required to facilitate openness will not happen whilst individual staff and organisations fear the culture of litigation that has been growing in recent years. Changing the culture to one of openness in individual employers is essential if the organisation is to support staff meet their individual registration requirements as well as ensure that the organisation meets its statutory requirements. This will include ensuring that supportive training, review and development opportunities exist as well as a system which does not condemn individuals for reporting their concerns to line managers and/or colleagues.
- 3.5 The CSP supports any move to ensure, enhance and demonstrate an organisational duty of candour, and the need to enshrine such expectations within statutory criminal law where necessary. We note that the Regulations will require that specific actions need to be taken when a specific harm threshold has been breached. There will need to be very clear guidance as to the definitions that support each level of harm. There is a risk of the perverse incentive to under-report events, or to 'down-categorise' events, in order to avoid candour disclosures. There will be many examples of where an open culture will be supported and promoted, but in environments where the culture remains driven by financial or other non-patient focused targets, there is a risk that the organisational culture will not support open reporting, and pressure may be put on staff to act accordingly as per our comments in 3.2.

**4. Do you have any views of the costs and benefits associated with the Duty of candour as set out in the draft impact assessment?**

4.1 We have no specific comments to make on this question.

**5. Do you think any of the proposals set out in this consultation documents could have equality impacts for affected persons who share a protected characteristic? The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. If so, please tell us about them.**

5.1 The Regulations may disproportionately affect any person receiving social care due to the disparity between candour disclosure levels between health and social care. In the context of protected characteristics, there may be equality impacts on older people and those with physical and mental health conditions, resulting in defined disability, receiving social care.



Professor Karen Middleton CBE FCSP  
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The Chartered Society of Physiotherapy  
25<sup>th</sup> April 2014

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For further information on anything contained in this response or any aspect of the Chartered Society of Physiotherapy's work, please contact:

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