Professional Liaison Group for the review of the standards of conduct, performance and ethics – 28 July 2014

Thematic review: Reporting concerns and dealing with mistakes

Executive summary and recommendations

Introduction

The first stage of the review of the standards of conduct, performance and ethics included a number of research and consultancy activities engaging a range of stakeholders about the standards.

Reporting concerns and dealing with mistakes has been identified as a key theme from the research findings, given the prevalence of discussion by stakeholders about the need for health and care professionals to report concerns about patient safety, deal with mistakes open and honestly and handle complaints appropriately.

This paper sets out the background, research findings, our current approach and approaches of other regulators to these topics. The paper also outlines the Executive's recommendations on this issue and provides a number of considerations for the discussion of the professional liaison group.

Decision

The professional liaison group is invited to discuss the attached paper and consider the recommendations made by the Executive in sections seven and eight.

Background information

None

Resource implications

None

Financial implications

None

Appendices

None

Date of paper

11 July 2014

Review of the standards of conduct, performance and ethics

Reporting concerns and dealing with mistakes

1. Introduction

1.1 The findings from the research activities undertaken during the first stage of the review of the standards of conduct, performance and ethics have been synthesised into a number of key themes.

1.2 These themes are to be considered by the Professional Liaison Group for the review of the standards of conduct, performance and ethics at its meetings between June and December 2014.

1.3 The theme identified in this paper incorporates a number of related issues that have gained particular currency in the health and care sector recently, and refer to the need for health and care professionals to report concerns about patient safety, deal with mistakes open and honestly and handle complaints appropriately.

1.4 This paper sets out the background, research findings, our current approach and the approaches of other regulators to these issues. The final sections of this paper set out the Executive's recommendations on this topic and key points for the group to consider.

2. Background

2.1 Recent inquiries into failures of care in the health and care sectors have demonstrated that concerns about poor care are not always raised, and those that are do not always result in rectification, despite the statutory obligations to do so.

2.2 The Francis inquiry into the failures of care at the Mid-Staffordshire NHS Foundation Trust raised particular awareness of these issues in the health sector, which found that there was 'too great a degree of tolerance of poor standards and of risk to patients' and a failure to share knowledge of concerns.

2.3 Coupled with other recent scandals, such as that at Winterbourne View, this has led to an increased focus on issues around whistleblowing and other mechanisms of reporting and escalating concerns across the health and care sectors. Particular focus has been on the pervasive culture in many health and care settings which is not conducive to these behaviours, and the related statutory obligations on organisations and individual professionals.

2.4 A related issue which has fed into wider discussion about culture change is that of a professional ‘duty of candour’ for health and care professionals, recommended by Sir Robert Francis in his report on the aforementioned inquiry. This refers to the need for professionals to demonstrate openness and honesty in identifying, reporting and acting to remedy mistakes and failures, including explaining the mistake to service users and seeking to put things right wherever possible. While these behaviours are expected of regulated professionals across the sector, there has been suggestion that these requirements need to be strengthened. Though the government is not taking forward a statutory duty of candour for individuals, it is taking this forward for organisations.

2.5 As part of the Professional Standards Authority’s (PSA) commission to the Department of Health about Candour, we outlined our current approach and acknowledged that the standards of conduct, performance and ethics are not currently as explicit as they perhaps might be in setting an explanation that a registrants should be both open with service users where harm has been caused, and proactive in putting matters right. We outlined that as part of our review of the standards we have identified a need to strengthen our requirements with respect to reporting and escalating concerns and candour, possibly through creating a dedicated standard. We also indicated our preference for not using the term ‘candour’ which we consider would be inaccessible to many, particularly service users and members of the public.

3. Current approach

3.1 We currently expect registrants to appropriately report any concerns they have in relation to the care of service users, escalating them if necessary, whether these be concerns about their own practice, that of a colleague, or the policies and procedures of employers.

3.2 Our standards of conduct, performance and ethics outline these expectations by requiring registrants to act to protect service users from any situation that puts their health or wellbeing in danger, and specifically mention that any such situation should be discussed with an appropriate person.

> ‘**1. You must act in the best interests of service users.**
>
> ‘You are personally responsible for making sure that you promote and protect the best interests of your service users… You must not do anything, or allow someone else to do anything, that you have good reason to believe will put the health, safety or wellbeing of a service user in danger… You must protect service users if you believe that any situation puts them in danger. This includes the conduct, performance or health of a colleague. The safety of service users must come before any personal or professional loyalties at all times. As soon as you become aware of a situation that puts a service user in danger, you should discuss the matter with a senior colleague or another appropriate person.

3.3 The standards also require registrants act with honest and integrity throughout their practice. Based on these general requirements we would expect registrants to act with honesty and openness when dealing with mistakes and handling complaints, working in the best interests of service users to rectify failures where possible.

> '**13. You must behave with honesty and integrity and make sure that your behaviour dies not damage the public's confidence in you or your profession.**
>
> 'You must justify the trust that other people place in you by acting with honesty and integrity at all times. You must not get involved in any behaviour or activity which is likely to damage the public's confidence in you or your profession.'

The standards of conduct, performance and ethics are available in full on our website: http://www.hpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics/

3.4 To underpin our approach to these issues we have provided further information for registrants about raising and escalating concerns on our website, including dedicated sections on whistleblowing and the steps registrants should take to raise concerns. This information is available on our website: http://www.hcpc-uk.org/registrants/raisingconcerns/

3.5 This section of our website also links to our formal guidance How to raise a concern, for any concerns about professionals on our Register. This guidance is available on our website: http://www.hcpc-uk.org/publications/brochures/index.asp?id=32

4. Research findings

4.1 For clarity the research findings relating to this theme have been structured in to three sections: reporting and escalating concerns, dealing with mistakes (incorporating consideration of the duty of candour) and handling complaints, though in practice there is considerable overlap between these procedures.

Reporting and escalating concerns

4.2 Findings from each of the activities undertaken during the research period for this review made mention of 'whistleblowing' requirements, and registrant's responsibilities to raise and escalate concerns about servicer user care appropriately.

4.3 Commissioned research carried out by The Focus Group with registrants and service users indicated that the standards needed to include a discrete standard relating to incident reporting and whistleblowing. A number of registrant participants highlighted that workplace culture is an important enabler in relation to raising concerns, and considered that a separate standard explicitly outlining registrants' obligations in this area would go some way in supporting registrants in environments that do not encourage these

behaviours. These findings were corroborated by the majority of registrants at events on these standards held throughout the UK. Other registrants indicated that a separate standard was not needed and current references in standards 1 and 4, quoted above, could be strengthened instead.

The Focus Group research report is available in full on our website: www.hpc-uk.org/publications/research/index.asp?id=733

4.4 Service users participating in The Focus Group's research drew upon their knowledge of recent scandals in the health and care sector to support their recommendation that the standards need to explicitly reference whistleblowing. Similarly, service user and carer participants in research carried out by Shaping Our Lives recommended that the standards are explicit about the duty of professionals to protect service users by whistleblowing, when appropriate. This requirement was considered particularly pertinent in the case of vulnerable service users who are most at risk of poor care, though no indication was made as to whether this should be expressed through the introduction of a discrete standard or through strengthening current references.

The Shaping Our Lives research report is available in full on our website: www.hpc-uk.org/publications/research/index.asp?id=735

4.5 The research team at Connect, a charity commissioned to undertake work with service users with aphasia and their carers, highlighted reporting concerns as one of the six main themes synthesised from workshops held with service users. Though there was some indication that the importance of raising concerns to combat poor care could be referenced in relation to standard 4, quoted above, the research recommendations concluded that the introduction of a separate standard on this issue would most appropriately address this issue.

4.6 Service users participating in Connect's research also acknowledged the role that employers and other organisations play in fostering an environment supportive to professionals raising complaints, though acknowledged that this was likely to beyond the scope of the standards.

The Connect research report is available in full on our website: www.hpc-uk.org/publications/research/index.asp?id=734

4.7 Events attended by employers and professional bodies unequivocally supported the introduction of a separate standard on reporting and escalating concerns. Though some felt this should explicitly reference whistleblowing, other participants highlighted that whistleblowing is only one example of a mechanism for reporting and escalating concerns out of a range of channels that are available to registrants. Most participants attending these events were clear that the current expression of these requirements in the standards were not strong enough. Participants recommended that the requirement on registrants should also include proactively following up on concerns they have

reported, seeking assurance that corrective action has taken place, and escalating concerns where this is not the case.

Dealing with mistakes

4.8 Registrant participants in The Focus Group's research indicated that the standards should also reference the need for registrants to respond, support and provide information to service users when things go wrong. Though they articulated the need for for employers to encourage a supportive atmosphere, they considered that a standard articulating the need to be open and honest about mistakes would go some way to tackling, what they considered to be, an opaque system in which professionals were too afraid to deal with mistakes appropriately.

4.9 The research findings of Shaping Our Lives and Connect corroborated the findings of workshops held with service users by charitable organisations such as Macmillan and Hearing Link, in which participants indicated a particular need for health and care professionals to be open and honest about care. Some participants in these workshops commented that this included ensuring transparency in arrangements and decisions when things go wrong, and recommended that this is particularly emphasised in the standards.

4.10 Colleagues in our Fitness to Practise Department, surveyed as part of our research, drew upon their knowledge of fitness to practise hearings in which honesty, insight and remedial action is looked upon favourably, to recommend that the standards more explicitly refer to the need for registrants to acknowledge and learn from mistakes, seeking corrective action where appropriate. Some employer participants who attended events on the review of the standards articulated similar views.

Handling complaints

4.11 In conjunction with handling complaints with honesty and openness, a small number of participants commented on the process of handling complaints, and how this should be shared with service users.

4.12 Some professional body representatives, attending an event on the review of these standards, articulated that the standards include a requirement on professionals in private practice to ensure that complaint procedures were in place and that service users were aware of the way in which they are able to raise concerns about their care. A few participants indicated that the standards should also a requirement for registrants in employed roles to follow local complaint procedures and employer policies on this issue.

4.13 This in part relates to findings from Shaping Our Lives' research which indicated that service users were unsure of how they would raise concerns about the care they had received from independent practitioners.

4.14 Service users taking part in workshops held with Macmillan commented that registrants should be required to ensure that service users are aware of how

they are able to complain at the start of care or treatment, and considered that this should be more explicitly reflected in the standards.

5. Other relevant considerations

5.1 As part of our response to Ann Clywd MP and Professors Tricia Hart's review of NHS hospitals' complaints systems, we have committed to considering a number of recommendations around complaint handling as part of our review of the standards of conduct, performance and ethics. This includes requirements for registrants to listen to complaints, deal with them honestly and openly, work to rectify the problem and keep a record of action taken. The Clywd and Hart review also welcomed discussions on a statutory 'duty of candour' to which we committed to consider the inclusion of the principles that underpin this duty as part of our review of these standards.

5.2 The HCPC is represented on an inter-regulatory working group on the 'duty of candour' to produce a joint statement on the recommendation in the Francis Report that a duty of candour should be a statutory requirement on health and care professionals. This statement is currently in development but includes that regulators support the four principles of this duty; that when something goes wrong registrants are required to recognise the mistake, be open and honest an acknowledge it, offer an apology and remedy or support to put matters right, and explain fully to the service user the short and long term effects. The statement also includes a commitment to ensure that these principles are reflected in our standards, guidance or appropriate work programmes.

6. Other standards and guidance

6.1 Other health and care regulators in the UK adopt different approaches to covering these issues in their respective sets of standards and accompanying guidance. The table below outlines the current position of each of the other regulators.

Regulator	Current approach
General Medical Council (GMC)	Good Medical Practice includes requirements for doctors to respond to risks safely. This includes promoting a culture that allows staff to raise concerns, acting immediately, reporting to someone in a position to act and making a record of the steps taken. The standards also require doctors to be open and honest with service users when things go wrong, make an apology and put matters right where possible. Published guidance about reporting and acting on concerns elaborates on these requirements providing information about the duty to report, overcoming obstacles and steps to raise a concern. The guidance also provides a section for those doctors in managerial positions or with extra responsibility with how complaints should be investigated. The GMC is

	currently working with the NMC to agree shared wording for doctors, nurses and midwives to address candour, near misses and the role of an apology, to appear in GMC guidance upon completion.
Nursing and Midwifery Council (NMC)	The NMC's current Code has a standards on 'managing risk' which includes acting without delay if someone is at risk, informing those with authority and reporting concerns in writing. Their standards on 'dealing with problems' includes being constructive and honest in response to complaints, not allowing complaints to prejudice care, acting immediately to put things right, explaining fully and promptly and cooperating with investigations. The draft revised version of the code has renamed these sections 'raising concerns and managing risk' and 'duty of candour and dealing with complaints' respectively and covers the issues outlined above with the addition of providing details to patients about how they are able to make complaints. The NMC have published guidance on raising concerns which includes sections on students, confidentiality, raising a concern, the role of clinical leaders, employers and relevant legislation.
General Pharmaceutical Council (GPhC)	The Standards of Conduct, Ethics and Performance have a number of standards related to this theme. This includes taking action to protect the wellbeing of patients and the public, challenging the judgment of other professionals where there is concerns about decisions, making sure there is an effective complaints procedure and following it accordingly, reporting and dealing with concerns appropriately and cooperating with any investigations. The GPhC also produce guidance on raising concerns which includes how to raise a concern, relevant law and guidance for employers. They also produce a guidance note about responding to complaints and concerns which focuses mainly on dispensing errors specific to the profession and how these errors should be reviewed and acted upon, including informing appropriate people, apologising and correcting errors where possible.
General Dental Council (GDC)	The Standards for the Dental Team include references to this theme in their standards including acting promptly if patients are at risk, taking measures to protect them, encouraging and supporting a culture of openness, ensuring effective procedures if in a managerial position and taking appropriate action in relation to concerns. Guidance on these standards in the same document cover types of risk, gagging clauses and how to raise concerns, create a culture of openness and an effective complaints procedure.

General Osteopathic Council (GOsC)	The Osteopathic Practice standards include a standard requiring registrants to act quickly to keep patients from harm, which includes taking steps to protect patients by discussing concerns with a colleague, employer, regulator, police or social services. The standards require those with the responsibility to ensure that systems are in place to raise concerns which comply with relevant law. The standards also include the requirement for registrants to be open and honest when dealing with complaints and respond quickly to them, this includes operating transparently and constructively with service users and making employers, insurers and regulatory bodies aware of complaints as necessary.
General Chiropractic Council (GCC)	The Code of Practice Standards include the requirement for registrants to protect patients from risk. This includes a substandard on managing complaints which requires registrants to have a written complaints procedure accessible to patients, deal promptly and fairly with complaints and tell patients about their right to refer to the regulator. This also includes a substandard on reporting concerns which includes protecting patients, establishing facts, discussing with colleagues and reporting to regulatory bodies if action isn't taken.
General Optical Council (GOC)	The Standards in Conduct outline that registrants must act quickly to protect patients where there is a good reason to believe the registrant themselves or a colleague is not fit to practise or undertake training.
Pharmaceutical Society of Northern Ireland (NISCC)	The PSNI's Code of Ethics contains the standards on this theme included in the GPhC's Standards of Conduct, Ethics and Performance, outlined above. The PSNI also produces guidance on raising concerns akin to that produced by the GPhC.
Care Council for Wales (CCW) Northern Ireland Social Care Council (NISCC) Scottish Social Services Council (SSSC)	The Code of Practice for social workers in Northern Ireland, Scotland and Wales is currently the same across all three care councils and was previously in place for social workers in England under the General Social Care Council. This Code outlines that social workers must protect service users from danger and harm using established processes and procedures and reporting dangerous, abusive, and discriminatory or exploitative behaviour. The Code also sets requirements to take complaints seriously, help service users make complaints, respond appropriately and inform an employer of appropriate authority.

	The CCW have published social work practice guidance which includes the requirement for registrants to inform employers about concerns with policies, procedures and care provision. This includes requirements to follow local polies, record concerns, and escalate to appropriate bodies where concerns are not acted upon by employers.

6.2 A range of local protocols and employer policies have been produced on the issues of reporting concerns and complaint handling to provide a framework for registrants in their workplace. For example, the NHS has a national whistleblowing charter for NHS employees.

6.3 A number of charitable organisations have focused on this issue to provide a range of guidance, tools and advice for raising and escalating concerns. For example, the Whistleblowing Helpline provided by Mencap for employers and employees in the NHS and social care sectors, and the guidance provided by Social Care Institute for Excellence for the social care sector.

7. Executive recommendations

7.1 The Executive recommends a dedicated standard referring to reporting and escalating concerns and dealing with mistakes which covers a number of key principles. This includes the need for registrants to:

- report concerns related to service user safety promptly and appropriately;
- be open and honest about mistakes with service users; and
- be proactive in putting matters right wherever possible.

7.2 The Executive considers that the term ‘candour’ should not be explicitly used in the standards as it is likely to be opaque to some audiences, particularly members of the public. To ensure that the standards remain as clear and meaningful as possible to both registrants and the public, the Executive recommends that the standards instead cover the key principles of this composite term, including being open and honest about mistakes and ensuring corrective action when possible.

7.3 The Executive also considers that the term ‘whistleblowing’ should not be specifically referred to in the standards given that this term normally refers to formal procedures for raising serious concerns about patient safety. Registrants should be expected to raise concerns they have at an early stage, for example, informally to their line manager. A wider term to encompass a range of approaches to raise concerns is therefore recommended.

7.4 The Executive’s recommendations are informed by the following considerations.

- The standards do not currently include a specific expectation that registrants should deal openly and honestly with mistakes and, importantly, take action wherever possible to put matters right.

- Currently the standards appear to set a high threshold for reporting concerns, with the reference to service users being in ‘danger’.

- The existing references to reporting and escalating concerns are split across two different standards which may make the requirements more difficult to identify.

- The majority of research participants, across stakeholders and professions, agree that a discrete standard be introduced to cover issues relating to reporting concerns and dealing with mistakes.

- Regulators have been encouraged in the Francis Report, and in subsequent reports and discussions, including in the PSA’s commission to the Department of Health on Candour to consider strengthening requirements around these issues in regulatory standards and guidance. In our recent submission to the PSA, we have committed to considering a dedicated standard on these issues.

- The majority of regulators include a dedicated standard on this issue, and provide explicit information and reporting and escalating concerns and dealing openly and honestly with mistakes.

- The standards are currently written in a clear and understandable way to ensure that they are relevant to both service users and members of the public and any revisions to the standards should ensure that this approach is maintained.

8. PLG considerations

8.1 A number of less prominent principles were raised by some research participants and are explicitly included in the approaches of some other regulators, though the PLG may find that some are incorporated in the three main principles outlined in 7.1.

- Registrants should apologise to service users when things go wrong.

- Registrants should follow up concerns reported.

- Registrants should provide service users with the information they need to make a complaint.

- Registrants should deal with complaints constructively and honestly.

- Registrants should follow local protocols and employer policies for handling complaints.

- Registrants should ensure that they have appropriate policies on raising concerns and handling complaints in place.

8.2 However, mandating an apology in the standards may not be the most meaningful way of ensuring that registrants are open and honest with service users and may raise issues related to liability.

8.3 When considering principles relating to complaint handling, it is important to note that the standards need to remain relevant to the working environments of as many registrants as possible. Those regulators that require registrants to have appropriate complaints policies and procedures in place are likely to be reflecting the context of the profession they regulate, in which professionals may commonly work in private practice. The majority of the professions we regulate however, are likely to work in large organisations in which staff have less responsibility for the complaints process. When considering principles relating to complaint handling, the PLG may wish to instead focus on the way in which registrants engage with complaints process, rather than their responsibility for the process itself. This may include a principle requiring registrants to 'give a constructive and honest response to anyone who complains about the care they have received' as included in the nursing and midwifery code, and strengthening current requirements in the standards to cooperate with any investigation or formal inquiry.

8.4 When considering the inclusion of further principles for inclusion to the standards, it is important to note that the standards of conduct, performance and ethics are designed to:

- outline high-level ethical requirements, and not cover profession or workplace specific detail, which will be covered in guidance provided by professional bodies, employers and other relevant health and care organisations;

- cover the underlying ethical principles to be applied to practice, rather than cover every ethical situation that a registrant may face throughout the course of their practice; and

- apply to all our registrants and cover a wide range of professions, settings and service users who have different roles and responsibilities.

8.5 The PLG is invited to discuss and agree the approach outlined in paragraphs 7.1 to 7.3.