May 2024

Duty of candour: NHS Providers' views, evidence and experience

Submission to the Department of Health and Social Care call for evidence

This briefing sets out NHS Providers' submission in response to a call for evidence by the Department of Health and Social Care (DHSC) on the application of the statutory duty of candour across the health and care system.

DHSC issued the call as part of its review into the operation, including compliance and enforcement, of the statutory duty of candour for health and social care providers in England. The review was announced on 6 December 2023 and the terms of reference for the review were published on the same date.

Responses were submitted via an online form with a strict word limit: our response focused on areas where we had insight to share from members, or knowledge of good practice or relevant research to draw upon.

Do you agree or disagree that the purpose of the statutory duty of candour is clear and well understood?

Agree

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. It helps those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in England in voluntary membership, collectively accounting for £115bn of annual expenditure and employing 1.4 million people.

A group of trust medical and nursing directors provided feedback on Duty of Candour (DoC) to the Department of Health and Care at a network meeting in March 2024. They were clear that the policy intent behind the DoC, to ensure an open and honest culture, and that there is complete honesty with patients and their representatives, is well-understood and welcomed in the NHS. The view was expressed that the 'true' DoC also involves working alongside patients and families to implement learning and actions after an incident has occurred. Where it works well, they told us, the DoC provides the impetus to ensure that staff are able to take the time to engage meaningfully with the patient and/or their families/representatives and to use their feedback to make improvements where relevant.

The directors noted various challenges with implementation however, which are included elsewhere in this submission.

Although we regularly interact with trust board members, and speak to them about a range of quality, safety and governance issues, they have not raised issues with us about the Regulation nor its application in practice.

We seek to place the DoC in the context of good governance, including quality governance, and ministers', patients' and trusts' expectation that NHS organisations:

- promote open, transparent behaviours from all,
- demonstrate compassion to patients and engage meaningfully with them and/or their representatives when something goes wrong,
- prioritise learning and do not blame when errors are made,
- prioritise and sustain a culture conducive to openness and compassion.

Do you agree or disagree that providers demonstrate meaningful and compassionate engagement with those affected when a notifiable safety incident occurs? This refers to the way providers engage with patients or service users, and families or caregivers.

Don't know

The following are insights from our ongoing work with NHS provider organisations and their staff:

- NHS staff can feel a tension between focusing on compassionate and meaningful engagement and focusing on the evidential/compliance requirements of the DoC.

- Staff can sometimes be anxious that they are unaware of the mental and/or physical health of the person with whom they are seeking to be candid, particularly when raising issues of harm which may have occurred in the past.
- It takes time and effort to obtain proper consent and keep patients and their families/caregivers informed. The well-documented understaffing in the NHS poses risks to staff and patient safety (Persistent understaffing of NHS a serious risk to patient safety, warn MPs - Committees - UK Parliament July 2022). Time pressures caused by understaffing might also make it very difficult to do everything needed to ensure full openness and transparency in all cases.
- There may be language, cultural and/or generational barriers to this which should be considered by NHS staff when they are engaging with patients and their families or caregivers, including when applying the DoC. Advocacy, where required, and accessible communications, are important.
- There can be a disconnect between relatively junior administrative colleagues who may manage the central DoC process and who will collate evidence to demonstrate compliance when a notifiable incident occurs, and health professionals who are required to provide information to enable the DoC to be complied with and/or to undertake an investigation in relation to a notifiable incident. That disconnect can be:
  - physical (staff may not be on the same premises, and paperwork may be slow to move between buildings or to be added to electronic systems)
  - related to relative priorities (the administrator is seeking information to meet a DoC timescale and the healthcare professional requires more time due to other competing clinical and administrative priorities)
  - around the purpose and outcome sought (where the healthcare professional has already verbally engaged with the patient/their family, they may view this as sufficient to fulfil their duty, while the administrator's role is to ensure the DoC checklist of actions progresses to completion).
  - Due to the sensitive nature of the DoC process, and the impact of an incident on patients and their families, it is not always possible for staff to ask for feedback on how patients/representatives found the DoC process. This means that evaluating the impact providers have during the DoC process is challenging, and providers may not have much opportunity to gather feedback to influence their approach.

Do you agree or disagree that the statutory duty of candour harm criteria that the incident must have been unintended or unexpected is clear and/or well understood?

Disagree

Medical and nursing directors told us that the definitions of 'unintended or unexpected' incidents present challenges for trusts, as well as for patients and their representatives.

CQC has sought to clarify the definition of 'unintended', which should refer to incidents arising during regulated activity (something unintended occurring during the provision of care), rather than to the outcome of the incident (that is, harm being unintentionally caused). However, the feedback we received indicates that this is not always well-understood. Directors told us that, except in extremely rare circumstances, no one intends to cause harm. In their discussions they focused on unintended outcomes of incidents rather than something unintended occurring during the provision of care. Directors also told us that most patients, including when consent has been fully and properly obtained, do not expect harm to occur. Even where procedures or interventions carry known and 'expected' risks that have been fully explained, when harm occurs 'there is always an issue' as far as the patient/their representative is concerned. These directors did not distinguish between harm caused in notifiable incidents and adverse but expected outcomes: candour and compassion were expected in both cases.

Our members would agree that candour is desirable in any circumstance where harm occurs. However, because it is a formal process including a series of checklists, the DoC can feel separate from the act of having meaningful ongoing engagement with patients, or their families or representatives. Directors also questioned whether CQC gave sufficient attention to engaging with patients and/or their representatives in assessing DoC compliance, as well as whether CQC inspectors were sufficiently consistent in their approach.

A challenge for NHS organisations and CQC respectively is how to demonstrate and assure compliance and how to successfully balance the desire for candour in all circumstances with criteria and a process for some incidents.

Do you agree or disagree that regulation and enforcement of the statutory duty of candour by CQC has been adequate?

Don't know

We do not have sufficient evidence to support our response to this question, apart from the feedback received by medical and nursing directors, reported in our response to the question above.

What challenges, if any, do you believe limit the proper application of the statutory duty of candour in health and/or social care providers?

In 2019, CQC published a review into the first year of NHS trusts implementing national Learning from Deaths guidance. Its findings were based on two years of inspection findings and are instructive and highly relevant to the DoC.

It found barriers and enablers to good practice.

Values and behaviours:

- Meaningful engagement with patients and their families/carers should be ongoing, not only after harm has occurred.
- Staff can be fearful of engaging due to lack of skills or confidence, fear of adding to distress, or a culture of blame within the organisation. Trusts should invest to support staff with appropriate skills and resources.

Leadership and governance:

- Someone senior needs to be, and be held, responsible.
- Challenge and interest at board level are important, including about whether there are strong control systems in place and lessons learned are shared and acted on.

Open and learning culture:

- An open, transparent, no-blame culture that is focused on learning is needed, not an inward-looking, fearful culture which can manifest in defensiveness and blame.
- Fear of litigation, negative public perception, or confrontation with families needs to be addressed, including through empowerment of staff to raise concerns and feel able to speak up and learn collaboratively.
- Board-led (top-down) and compliance-focused cultures are not conducive. Learning should be a central value of the organisation, and staff across the organisation should see the benefit in involving patients and their representatives in reviews and learning as appropriate.

Resources, training and support:

- Having sufficient resource (in terms of staff capacity and capability, support and training) is an importance factor in a trust's ability to deliver effective reviews and investigations. Challenges can

include allowing staff time away from clinical duties and protecting time for engagement and reviews.

- Factors that influence the allocation of appropriate resources include the board's willingness (prioritisation) and availability of funding as well as competing priorities.
- Prioritisation of resourcing, support and desirable culture-setting from the Integrated Care Board (the CQC noted Clinical Commissioning Groups as they were the commissioners at the time) is also important.

We would also add the following observations:

- Organisational culture is not homogenous: subcultures exist within teams, departments and services. Aggregated views of organisational compliance and the application of the DoC may not paint the full picture where organisational pockets of excellent practice and transparent, supportive, patient-facing cultures may exist alongside closed cultures.
- Different types of trust exhibit different characteristics that may present barriers to the open, transparent application of the DoC. For example, there is variation across the sector on NHS staff survey metrics around staff engagement in decision-making and improvement, and measures about reporting of and action taken about errors and near misses.
- Staff working in primary care note that some patients opt to use the NHS under an alias – which is particularly common for those using sexual health services. This makes it impossible for staff to contact the patient to fulfil DoC.

Provide any further feedback that you feel could help shape our recommendations for better meeting the policy objectives of the duty of candour.

The NHS staff survey is useful to understand the perspectives of staff implementing the DoC, and the cultures in which they work:

- 32.40% of staff said there were enough staff at their organisation.
- 75.14% said care of patients/service users is their organisation's top priority.
- 70.55% said their organisation acts on concerns raised by patients.
- 71.28% would feel secure raising concerns about unsafe clinical practice with 56.81% confident their concern would be addressed.
- 62.31% feel safe to speak up about anything that concerns them with 50.07% confident their concern would be addressed.

Staff confidence in raising concerns about unsafe clinical practice is lower than it was five years ago. It is essential staff feel free to speak up and work in a psychologically safe environment. This is an indication of how open the culture is in NHS organisations – and despite concerted action on behalf of trusts to improve in this area, we are not yet seeing the breakthrough that is required. While more staff are reporting confidence in their organisation addressing concerns, further action is needed to ensure patients get the safe, high-quality care they deserve.

On organisational culture, the research of Professor Mary Dixon-Woods is instructive. She notes the relevance of building 'problem-sensing' cultures: where weaknesses in systems relating to quality and safety are actively sought out, typically using multiple techniques and sources of organisational intelligence. She contrasts this with 'comfort-seeking' cultures: giving undue credence to reassurance provided by the data available, and being unwilling to seek out information that might challenge the sense that all is well.

In problem-sensing organisations, candour is expected, and owning issues and errors more commonplace as they are seen as learning and improvement opportunities, not something to be hidden for fear of punishment. Such cultures cannot be achieved solely through top-down efforts or emphasis on compliance, but are also "crucially reliant on the broader culture and systems of the organisation, particularly the extent to which their values, norms, behaviours and institutional capacities are oriented towards openness and learning." (Organisational culture: problem-sensing and comfort seeking, 2023).

Our reflections in this submission are summarised below:

- The DoC should support organisations and their employees to do the right thing, and be part of an approach that builds open, compassionate cultures across health and care.
- Work to build such cultures is more likely to drive the behaviours sought by ministers, patients, and trust staff and leaders than compliance-based approaches.
- Careful consideration should be given to how CQC seeks and assesses compliance with the DoC, to avoid unintentionally creating confusion about definitions and thresholds or tick box cultures which can detract from the perceived relevance of the DoC to openness and candour.
- Patients', families and caregivers' perspectives on candour should be given due weight when assessing how well organisations are doing, and differences between and across teams within organisations should not be ignored.
- Practical considerations around timeliness and the availability of information should be considered if the process is redesigned. This is particularly important when the NHS is understaffed.

Contact: Izzy Allen, senior policy advisor (governance) izzy.allen@nhsproviders.org