NHS Resolution's response to the Department of Health and Social Care's Duty of Candour Review 2024

Our answers, set out below, were submitted via the Department's online portal.

Answers

"About you" questions

In what capacity are you responding to this survey? On behalf of an organisation

What sector does your response relate to? Healthcare in the NHS

Please provide the name of your organisation (optional) NHS Resolution

Are you happy to share your email address with the Department of Health and Social Care? Yes

Main questions

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

   Answer: Disagree.

   We will answer this question by focusing on whether healthcare providers understand the purpose of the statutory duty of candour.

   Based on our Safety and Learning Team's ongoing engagement with healthcare providers, we understand that there is a tendency for healthcare professionals to focus on the minutiae of the statutory duty rather than recognising the important, overarching purpose. That purpose is to direct health and social care providers to be open and transparent with people receiving care.

   One way to support healthcare providers to be open and transparent is for the NHS to have an embedded just and learning culture. As an organisation we continue to promote the benefits of such a culture in the NHS, where there is a balance of fairness, justice, learning and taking responsibility for actions. To assist the NHS to be open and honest we produced a 'Just and Learning Culture Charter' for organisations to adapt and adopt, in our *Being Fair* report (1). The creation of the charter was informed by HR directors, regulators, other NHS arm's length bodies and patient safety experts. In 2023, we released *Being Fair 2* (2), which builds on the messages of the first report and sets out the benefits to an organisation of adopting a more reflective approach to learning from incidents and supporting staff.

To further help organisations embed this just and learning culture, we continue to promote key messages from our 2017 leaflet titled *Saying Sorry* (3). The leaflet attempts to make several things clear: that not only is saying sorry when an incident has taken place the morally right thing to do, it is also a statutory, regulatory and professional requirement. We make clear that saying sorry is always the right thing to do, is not an admission of liability and is the first important step to learning from what happened and preventing it from recurring.

We also encourage the review team to consider the impact of the introduction of the Patient Safety Incident Response Framework (PSIRF) in 2022 on the understanding of the purpose of the statutory duty of candour. In December 2023, Bevan Brittan, one of our legal panel firms, presented a webinar (4) on the relationship between PSIRF and the statutory duty of candour, including how to align health obligations under the duty of candour within PSIRF.

This answer should be read in conjunction with our response to question two.

(1) https://resolution.nhs.uk/resources/being-fair/
(2) https://resolution.nhs.uk/2023/03/30/being-fair-2-improving-organisational-culture-in-the-nhs/
(3) https://resolution.nhs.uk/resources/saying-sorry/
(4) https://www.bevanbrittan.com/insights/events/2023/2023-12-05-psirf-and-the-duty-of-candour/

2. Do you agree or disagree that staff in health and/or social care providers know of, and understand, the statutory duty of candour requirements?

Answer: Neither agree nor disagree.

There is mixed level of understanding and awareness of the statutory duty of candour amongst healthcare providers.

NHS Resolution's stakeholder engagement has identified that some healthcare providers do not understand the difference between the statutory duty of candour and professional duty of candour. 75% of our duty of candour advisory group (including 14 external stakeholders from trusts and regulatory bodies) felt that healthcare providers struggled to understand both duties. This confusion may be contributing to a lack of understanding amongst staff.

To help the NHS workforce understand the similarities and differences that exist between the duties, in 2022 we published our Duty of Candour animation. (1) This eight-minute animation offers guidance on the importance of being open and honest and how the two duties can be fulfilled effectively.

We consider that there is an appetite to better understand the statutory duty and professional duty as the animation is our highest viewed animation ever released and over 300 people attended our candour virtual forum in September 2022. (2)

The animation forms part of NHS England's Patient Safety Syllabus which currently has 1000 enrolments and it has been embedded within healthcare provider's e-modules.

Confusion about the duty of candour requirements was also a key theme in our first Early Notification scheme progress report. (3) It indicated that of 'the cases surveyed, there had been limited support for staff, insufficient family involvement and confusion over the duty of candour'. In this cohort, 77% (71/92) of families were notified by the trust that an incident had occurred, and 35% (32/92) were recorded as having been offered an apology. This low figure is concerning and, in the report, we emphasised that all NHS organisations are required to comply with the duty of candour and urgent action is required by the trusts, commissioners and the Care Quality Commission to drive improvement in this area.

Compliance with the statutory duty of candour forms part of Safety Action 10 of our Maternity Incentive Scheme (MIS). (4) MIS requires all Trusts delivering maternity care to report and self-certify their compliance with 10 Safety Actions. Detailed information about the Duty of Candour requirements and Regulation 20 are provided in the MIS technical guidance document. In year five of the MIS, all but two of the participating Trusts were found to be compliant overall with this Safety Action. This is a positive development, as over successive years we have found a lack of evidence from Trusts that the statutory duty of candour has been complied with, which is why we strengthened Safety Action 10 in September 2020. The most recent results from year five suggests that there is a good level of understanding and awareness of the statutory duty in the maternity space.

(1) https://resolution.nhs.uk/resources/duty-of-candour-animation/
(2) https://resolution.nhs.uk/resources/duty-of-candour-virtual-forum/
(3) https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/
(4) https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

3. Do you agree or disagree that the statutory duty of candour is correctly complied with when a notifiable safety incident occurs?

Answer: Neither agree not disagree

It is not NHS Resolution's role to assess whether the statutory duty of candour is being complied with. However, we do have some helpful insights relating to compliance in maternity services as part of our Maternity Incentive Scheme (MIS) (1).

For context, MIS requires all trusts delivering maternity care and participating in the scheme to report and self-certify their compliance with 10 Safety Actions. Compliance with the statutory duty of candour forms part of Safety Action 10 of MIS. Over the years although only a few trusts have not met this safety action, more generally we have found a lack of evidence from Trusts meeting this Safety

Action that the statutory duty of candour has been complied with, which is why we strengthened Safety Action 10 in September 2020.

Evidence for this Safety Action relies on trust board sight of compliance to help answer:

"Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?"

In year five of the MIS, all but two of the participating Trusts were found to be compliant overall with Safety Action 10. This suggests that there is a good level of compliance with the statutory duty in maternity care.

The Care Quality Commission (CQC) and the Maternity and Newborn Safety Investigations programme consider whether they have any concerns or information that may call into question the MIS submission made by the Trust. For example, the CQC may highlight that they have recently carried out an inspection that has raised concerns about compliance with the duty of candour. This may result in asking the Trust to reconfirm their submission and provide evidence to NHS Resolution to support their submission, in line with the reverification process.

Positively, the duty of candour has not been an issue that we have needed to escalate following CQC benchmarking reports, although we have had one instance where the duty of candour was raised by a whistleblower. In that case, after asking the Trust to reconfirm their position and provide evidence, they recognised their non-compliance and downgraded their compliance for Safety Action 10.

(1) https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

4. 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.

   Answer: Don't Know

   NHS Resolution cannot speak to whether providers are demonstrating meaningful and compassionate engagement with those affected when a notifiable safety incident occurs. However, it is important to flag that having the right culture can assist healthcare providers to partake in meaningful and compassionate conversations with patients and their families. As an organisation we continue to

promote the benefits of a just and learning culture in the NHS, where there is a balance of fairness, justice, learning and taking responsibility for actions.

In our *Saying Sorry* leaflet (1) we make clear that saying sorry is always the right thing to do, is not an admission of liability and is the first important step to learning from what happened and preventing it from recurring. A misunderstanding of this may lead to some staff being afraid of the consequences of making an apology, limiting their ability to be compassionate.

Focusing on the duty of candour, we have made it clear in our 2022 Duty of Candour animation (2) that healthcare providers should 'ensure conversations are bespoke to [the patient's] needs, consider the sensitivities of the situation and always ensure that all communication is personalised and empathetic'.

Complementing these resources is our continuing work on dispute resolution. We believe that the resolution of disputes in healthcare can be achieved in a way that facilitates a relationship of trust between the parties and support our principles of a just and learning culture. (3)

Furthermore, in our first Early Notification scheme progress report (4) published in 2019 we emphasise the importance for communication and 'difficult conversations' training for those discussing care with families who have been involved in harm.

(1) https://resolution.nhs.uk/resources/saying-sorry/
(2) https://resolution.nhs.uk/resources/duty-of-candour-animation/
(3) https://issuu.com/erencan-iconicmediasolutions.c/docs/digital_-_issue_18_-_medico-legal_magazine (page 19)
(4) https://resolution.nhs.uk/wp-content/uploads/2019/09/NHS-Resolution-Early-Notification-report.pdf

5. Do you agree or disagree that the 3 criteria for triggering a notifiable safety incident are appropriate?

   Please note that we will not provide an answer to this question as it falls outside of our remit.

6. Do you agree or disagree that the statutory duty of candour harm thresholds for trusts and all other services that CQC regulates are clear and/or well understood?

   Please note that we will not provide an answer to this question as it falls outside of our remit.

7. Linked to the previous question, 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?

Please note that we will not provide an answer to this question as it falls outside of our remit.

8. Do you agree or disagree that notifiable safety incidents are correctly categorised and recorded by health and/or social care providers, therefore triggering the statutory duty of candour?

   Please note that we will not provide an answer to this question as it falls outside of our remit.

9. Do you agree or disagree that health and/or care providers have adequate systems and senior level accountability for monitoring application of the statutory duty of candour and supporting organisational learning?

   Answer: Don't know

   We want to highlight that this question has two elements that may benefit from separating from one another. The first relates to the adequacy of systems and senior level accountability for monitoring the application of the statutory duty of candour. The second, which is important in its own right, is whether we agree or disagree that health/social care providers have adequate support for organisational learning. We will take each in turn.

   Firstly, whilst we are not able to comment on the adequacy of the systems and senior level accountability for monitoring the application of the statutory duty of candour, we do have insights to share relating to the maternity space as part of our Maternity Incentive Scheme. (1) More information can be found in our answers to questions two and three.

   When it comes to the second part of the question, although we cannot answer whether there is adequate support for organisational learning about the statutory duty of candour, we want to emphasise the benefits of embedding a just learning culture in the NHS. Such a culture is one where there is a balance of fairness, justice, learning and taking responsibility for actions. To assist the NHS, we set out a 'Just and Learning Culture Charter' for organisations to adapt and adopt, in our *Being Fair* report. (2) In 2023, we released *Being Fair 2*, (3) which builds on the messages of the first report and sets out the benefits to an organisation of adopting a more reflective approach to learning from incidents and supporting staff.

   (1) https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/
   (2) https://resolution.nhs.uk/resources/being-fair/
   (3) https://resolution.nhs.uk/2023/03/30/being-fair-2-improving-organisational-culture-in-the-nhs/

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

Answer: Don't Know

As we do not have oversight of the Care Quality Commission (CQC), we cannot comment on the adequacy of how they regulate or enforce the statutory duty.

NHS Resolution fully support the work of the CQC to regulate and enforce the statutory duty of candour. Key NHS Resolution resources on the topic of candour, such as *Saying Sorry* (1) are helpfully incorporated into the CQC's 'Regulation 20' webpage. (2) This helps providers understand that saying sorry is always the right thing to do, is not an admission of liability and is the first important step to learning from what happened and preventing it from recurring.

It is positive to see the CQC is continuing to reflect on their approach to 'learning culture' (3) most recently though seeking feedback from system partners on their new quality statements. They are doing this to ensure they take the best approach to assessing providers on this topic and to ensure they can give providers the best quality information on what good looks likes. (4)

(1) https://resolution.nhs.uk/resources/saying-sorry/
(2) https://www.cqc.org.uk/guidance-providers/all-services/regulation-20-duty-candour
(3) https://www.cqc.org.uk/guidance-regulation/providers/assessment/single-assessment-framework/safe/learning-culture
(4) https://citizenlabco.typeform.com/to/xzWepGI4?typeform-source=lnks.gd

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

NHS Resolution recognises that there are several challenges with implementing the statutory duty of candour especially considering the current wider system pressures on healthcare providers.

Firstly, we suggest that challenges in properly applying the statutory duty of candour may stem from difficulty embedding a just and learning culture in the NHS. Emphasising the need to embed this culture, where there is a balance of fairness, justice, learning and taking responsibility for actions is something we set out in our *Being Fair* (1) report in 2019 and continues to be a key driver underpinning our work.

You might be interested to know that the *Being Fair* report set out three challenges that need to be addressed to help the system learn from incidents:

1. Fear- There is a substantial fear of the consequences; fear of being blamed, fear for future employment and fear of what colleagues, families and friends will think which prevents people from sharing and learning.

2. Equity-There is significant variation between NHS trusts as to the likelihood of staff being discipline d or suspended. Research has shown that different individuals can also experience inequity, discrimination and suffer disproportionate disciplinary action, especially among black, Asian and minority ethnic (BAME) staff groups.

3. Fairness- When things do not go as planned people experience stress, burnout, and subsequent loss of productivity. This is compounded by the current culture of incivility, bullying and harassment. (1)

These challenges may be of interest when you consider the challenges limiting the proper application of the statutory duty of candour.

When it comes to the fear of consequences from being open and honest when something goes wrong, we know that delayed or poor communication makes it more likely that the patient will seek information in a different way such as complaining or taking legal action. (2)

A second key challenge limiting the proper application of the statutory duty is healthcare provider confusion between the two duties of candour. Through stakeholder engagement, our Safety and Learning team identified that healthcare providers sometimes do not understand the difference between the statutory duty of candour and professional duty of candour. As mentioned above, to help those working in the healthcare sector to understand the similarities and differences that exist between the professional and statutory duties of candour, in 2022 we published our Duty of Candour animation. (3) The eight-minute animation also offers guidance on the importance of being open and honest and how the two duties can be fulfilled effectively.

(1) https://resolution.nhs.uk/resources/being-fair/
(2) https://resolution.nhs.uk/resources/saying-sorry/
(3) https://resolution.nhs.uk/resources/duty-of-candour-animation/

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

NHS Resolution are committed to supporting the Department and system partners with this important work.

We would be happy to be part of any further discussion in relation to this review, and work with you to progress further.