professional standards authority
for Health and Social Care

# A compendium on candour

## A compilation of blogs on the professional duty of candour

# What is the professional duty of candour?

Basically, it means being honest when something goes wrong – we have supported the introduction of a statutory duty of candour for organisations that provide healthcare. We believe there are immense benefits to be had for the care and treatment of people in the health and care system if it is open, transparent and honest. Professionals also have a duty of candour under the codes set by their professional regulator. To raise awareness about the professional Duty of Candour, we have provided advice to government, commissioned research and published a series of blogs from different perspectives.


**A healthcare professional makes a mistake – it could be a mix up in medication, a miscommunication with a team member.....**

It sounds simple, it seems easy – if something goes wrong just tell the truth, our research revealed, there are barriers that can discourage professionals from being candid. Find out more in our report ***Telling patients the truth when something goes wrong***

# A compilaton of blogs published on the professional duty of candour

## A tale of two duties (of candour)

Amy Hopwood, Policy Manager at the Care Quality Commission, writes about the organisational duty of candour: the difference between it and the professional duty of candour; the barriers that can hinder both organisations and professionals from being candid; and CQC's plans for launching new guidance in the spring.

## The duty of candour - where are we now?

Peter Walsh, Chief Executive of Action against Medical Accidents, sums up what progress has been made since the introduction of the organisational and professional duties of candour, but also questions what difference they have made.

## Truth will out? Two sides of the candour coin

We look at two sides of the professional duty of candour – in the first part, Kisha Punchihewa our head of legal looks at it from the legal point of view in the context of fitness to practise. In the second part, policy manager, Dinah Godfree looks at the possible barriers to telling the truth and why being candid can be much more complicated than 'simply telling the truth' makes it sound.

## The professional duty of candour: widening the lens

Annie Sorbie and Zahra Jaffer of the University of Edinburgh's School of Law, discuss that momentum needs to be maintained on embedding the professional duty of candour in healthcare professionals, but we also need to widen the lens beyond individual interactions and direct attention to the wider context in which healthcare is provided.

## The professional duty of candour is a commendable principle but to what extent can regulators influence registrants to put it into practice?

Trust is undoubtedly the basis on which any successful healthcare professional-patient relationship is going to be built. The professional duty of candour – that is telling the truth when something has gone wrong with care – is integral to building this trust.

## The role of regulators in encouraging a Speak Up culture

'See it Say it. Sorted' – you usually hear this if you are taking any kind of public transport and it applies to being vigilant – keeping a look out for unusual behaviour that could put people at risk. However, you could also apply this principle to speaking up and raising concerns in a health/care setting – concerns which, if ignored, could also put people at risk.

# The duty of candour - where are we now?

Amy Hopwood | Policy Manager, Care Quality Commission

Amy Hopwood, Policy Manager at the Care Quality Commission, writes about the organisational duty of candour: the difference between it and the professional duty of candour; the barriers that can hinder both organisations and professionals from being candid; and CQC's plans for launching new guidance in the spring.

26 February 2020

It has been fascinating reading the recent blogs about candour on the Professional Standards Authority website, and I'm pleased to be asked to respond with a view from the **Care Quality Commission (CQC).** Although the Authority, and the organisations it regulates, are primarily concerned with the professional duty of candour and CQC with the organisational duty, there is a great deal of overlap, and it seems that many of the barriers to proper implementation of these duties are common to both. It also seems that as our regulation of the two duties matures, we are both increasingly focusing on the role that organisational culture plays. In this blog I will explain what the organisational duty of candour covers; how it aligns with the professional duty; CQC's experience of regulating the duty; and our plans for the future.

## What is the organisational duty of candour?

The Duty of Candour is laid out in **Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**. It applies to any organisation carrying out health and/or social care activities which are regulated by the Care Quality Commission.

Regulation 20 is specific about the procedure to carry out the duty of candour, and lays out:

- the thresholds of harm which should trigger the duty
- the various steps, meetings and records that should be carried out
- what those meetings and records should cover
- that the process should be carried out in a timely manner
- that appropriate support should be provided to the person using the service or their representatives.

## How does it work with the professional duty of candour?

Both duties have similar aims, that is, to ensure that those providing care are open and honest with the people using their services, particularly when something has gone wrong; however, the organisational duty of candour applies only in certain situations, known as 'notifiable safety incidents'. These are defined in detail within the regulation.

This means that there will be cases where the professional duty applies but not the organisational one. Where the organisational duty does apply, it may well be carried out by the same person who carries out the professional duty, so it is important to remember that the organisational duty carries with it particular steps that must be covered and records that must be made. Carrying out the professional duty alone will not be enough to meet the requirements of the organisational duty of candour.

While the responsibility for carrying out the professional duty is clearly located with the individual professional, the responsibility for the organisational duty is located with the provider of regulated activities, and in particular the 'registered person' who represents that provider to CQC. In practice, however, notifiable safety incidents will occur at the point of care, so the registered person is more often responsible for ensuring that the duty of candour is being carried out appropriately by the professionals they employ, rather than actually carrying it out themselves. The two duties should mutually reinforce each other, creating a culture where it is in the providers' interests to encourage their staff to be candid, and where professionals feel safe and supported to speak up and be honest when things go wrong.

Amy Hopwood | Policy Manager, Care Quality Commission | 26 February 2020

## How CQC currently regulates the duty of candour

The Care Quality Commission has been responsible for regulating the organisational duty of candour since November 2014 for NHS Trusts and April 2015 for other health and social care providers. During the registration process, we look for evidence that a prospective care provider understands Regulation 20 and will have robust systems in place to adhere to it from day one of operation. When we inspect an existing service, we review the provider's performance around the duty, by interviewing staff, looking at data and reviewing their records. The evidence we find will affect the overall ratings we award to the service and may even lead to enforcement action.

CQC can enforce breaches of parts 20(2)(a) and 20(3) of the regulation and is able to move directly to criminal enforcement action, including prosecution following an investigation. In 2019 we issued 14 Fixed Penalty Notices, in respect of eight incidents, occurring at two NHS Trusts.

## Future plans

Towards the end of 2018, CQC undertook a review of the way we regulate the duty, consulting with our own staff, providers and other external stakeholders. We found that there remained some confusion around various aspects of the Regulation. For example, it can be hard for providers to determine which incidents fall into the harm threshold and require action (especially where thresholds are differently defined for different sectors). Others have queried what the Regulation means by 'reasonable' in terms of timescales and the support offered; how the duty applies in retrospective case reviews; and what to do when the notifiable incident has occurred in a different organisation.

We are planning to clarify these and a wide range of other questions when we launch new guidance for both providers of care and our own inspectors in the spring.

Any contributions to help us improve the guidance would be very welcome, please email Amy at amy.hopwood@cqc.org.uk

# A tale of two duties (of candour)

Peter Walsh | Chief Exectutive, AvMA

Peter Walsh, Chief Executive of Action against Medical Accidents sums up what progress has been made since the introduction of the organisational and professional duties of candour, but also questions what difference they have made.

30 January 2020

It is difficult to believe that until the Westminster parliament felt compelled at last to act following the Mid Staffordshire public inquiry, no NHS organisation was in breach of any statutory regulation or law if it covered up incidents which had harmed or even killed patients. It is surely something that will shock and intrigue future historians and students of the NHS. In effect, the system had frowned on cover ups, but had not been prepared to do anything serious to stop them and continued to tolerate them until public pressure became unbearable. The statutory duty of candour came into force in England at the end of 2014 and alongside it a **renewed commitment** on the part of health professional regulators to promote and regulate health professionals' professional duty of candour.

The lack of a statutory duty or any effective mechanism to hold either healthcare organisations or individuals to account for failing to be open and honest had long been a massive concern to Action against Medical Accidents (AvMA – the UK charity for patient safety and justice), based on the experience of many of the thousands of people we advise and support every year.

The **case of Robbie Powell** had become a powerful symbol of the need for change, and no individual has done more to make the case than Robbie's father Will Powell. AvMA will always be grateful for the Powell family's work and for them allowing AvMA to use Robbie's name in our campaign for a statutory duty of candour on organisations and more rigorous regulation of the professional duty.

In spite of stern resistance from some parts of the system, our campaign was eventually successful in England. It has been followed by the introduction of a statutory duty in Scotland, and plans to bring one in in Wales and Northern Ireland. It is undeniable that awareness has been raised. It even featured in a recent episode of Holby City! There is now a stated determination in all parts of the United Kingdom to give this issue the priority it deserves. However, the jury is out as to just how much difference the duties of candour are making in practice.

The duty of candour (both organisational and professional) is primarily about changing culture and giving prominence to the necessity of openness and honesty when things go wrong. It is about avoiding cover ups rather than having to punish those responsible for them. Changing culture can never be a quick fix, but we now have five years' experience since the statutory duty was introduced in England and the health professional regulators refreshed their guidance on the professional duties. Anecdotally, things have got better.

The health professionals and managers I speak to overwhelmingly agree that we are better off having a statutory duty of candour. Investigators and complaints staff tell me that they feel more empowered to be fully honest. **Research** led by Professor Graham Martin found that this had been the most effective of a range of measures designed to improve openness in the NHS in England.

However, this is tinged with the feeling that the quest for compliance has in some places led to a 'tick box' approach. Added to that, it is still the case that some patients and families have continued to experience a lack of openness and honesty. Research by AvMA in 2016 ***Regulating the Duty of Candour*** found that the Care Quality Commission's (CQC)

regulation of the statutory duty had so far been pretty woeful, and that no organisations had been held to account for breaches. Our report in 2018 ***Requires Improvement*** found that the situation had improved and regulatory action had begun to be taken over breaches but there were still significant weaknesses in regulating and promoting the duty. The Professional Standards Authority **report on the professional duty of candour in 2019** found that regulators had improved their approach to regulating the duty of candour but that much more remained to be done system-wide to create the right environment for honesty and candour to flourish.

England is still playing catch up over its statutory duty of candour. One has to remember that the Department of Health had been strongly against bringing it in and this was something that was forced upon it by the Mid Staffs inquiry recommendations and a mixture of public and political pressure. It was introduced in a hurry without the necessary preparation and training. AvMA even had to produce the only national information leaflet for the public on the duty of candour (endorsed by the CQC). There remains no central training and awareness campaign to support the implementation of the duty of candour in England and a review of the legislation and guidance is well overdue.

Nonetheless, progress has begun to be made and the introduction of statutory duties in Scotland, Wales and Northern Ireland provide an opportunity to learn from the experience in England. As the Professional Standards Authority report concluded, what is needed is a joined-up approach by Government, regulators and others to both design, implement and regulate for openness and honesty in a meaningful way. The statutory duties on organisations and those that apply to individual health professionals need to complement and support each other. If we get the duty of candour right, it will be the biggest and most overdue advance in patients' rights and patient safety that we have ever seen in health and social care.

You can find out more about Action against Medical Accidents (AvMA) from their website at **www.avma.org.uk**

# Truth will out? Two sides of the candour coin

Kisha Punchihewa | Head of Legal
Dinah Godfree | Policy Manager
Professional Standards Authority

In this blog we look at two sides of the professional duty of candour – in the first part, Kisha Punchihewa our head of legal looks at it from the legal point of view in the context of fitness to practise, citing some examples where professionals have failed to be candid. In the second part, policy manager, Dinah Godfree looks at the possible barriers to telling the truth and why being candid can be much more complicated than 'simply telling the truth' makes it sound.

29 November 2019

**The duty on regulated healthcare professionals to be candid when something goes wrong with patient care was introduced following the tragic events at Mid Staffordshire. However, during the course of writing this blog, more tragic events – this time at Shrewsbury and Telford Hospital Trust – are coming to light and a failure to be candid when something has gone wrong with care continues to be an issue. So what is it that can hinder healthcare professionals from being candid? Our recent research looked at the kind of issues that can deter professionals from being candid. Also, as part of our scrutiny of the regulators' final fitness to practise decisions, we have seen cases where a professional has not been candid when something has gone wrong or where a regulator's fitness to practise panel has not treated a lack of candour seriously as it should have been treated.**

## What does it mean to be candid?

**Kisha Punchihewa | Head of Legal**

It seems obvious when we are looking at cases after the event – something goes wrong, you know something has gone wrong and as a healthcare professional you should be open about it…but that doesn't always happen.

Telling the truth has been something we expect of our healthcare professionals, but it was brought into focus following the tragic events at Mid-Staffordshire. There is now an organisation duty of candour as well as a professional duty of candour; it is the professional duty that I am going to look at it in more detail here.

Healthcare professionals must:

- tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong;
- apologise to the patient (or, where appropriate, the patient's advocate, carer or family);
- offer an appropriate remedy or support to put matters right (if possible); and
- explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long terms effects of what has happened.

But this does not always happen and we know that it does not happen – one part of the solution is understanding the problem. The Authority's report ***Telling patients the truth when something goes wrong*** looked at research around the barriers to candour – those things that stop people from telling the truth. We have seen these barriers to candour in cases we have brought via our [Section 29 appeal process] and I am going to focus on a couple of them.

Kisha Punchihewa | Head of Legal

## Case study 1 – A consultant neurosurgeon

This case involves a consultant Neurosurgeon let's call him Dr Smith (not his real name). Dr Smith's patient required surgery on his back. The patient underwent his operation but did not know that the operation had been performed on the wrong site. We don't know if Dr Smith realised this immediately after the operation. However, the patient complained about continued pain at a follow-up appointment. The patient was then told to come in for more surgery as more bone needed to be taken off because not enough disc had been taken away during the first operation.

What Dr Smith did not say is 'I'm sorry – I operated on the wrong site of your spine and that is why you are still in pain. I need to correct that mistake.'

What he did do however was say nothing, allowing his colleagues and, most importantly, his patient to believe that this second surgery was needed because essentially the first one had not quite done the job. The second surgery was successful. Dr Smith then completed the medical records containing false descriptions of the surgery. This meant he has either deliberately caused or allowed his colleagues to become a part of his deception. He also sent an incorrect letter to the patient's GP.

None of this would have come to light if the patient had not brought a clinical negligence claim against the Trust. The doctor who he employed as his expert had noted the wrong-site surgery when reviewing the medical records. This review took place two years after the first surgery.

This is not a case of someone making a spur-of-the-moment poor judgement call, but is a series of dishonest acts. There were enough opportunities for Dr Smith to be candid with both his patient and his colleagues. Why wasn't he? When interviewed by his employer Dr Smith said when he discovered he had operated on the wrong site on his patient's spine he thought it was a disaster; he knew that he should have informed his manager about the surgical error; but felt that reporting the wrong-site surgery 'opens a can of worms' and he was aware of that.

The bottom line here is that he put his own interests before those of his patient and he lacked the moral courage to own up to his mistake.

## Case Study 2 – Nurse Jones

Nurse Jones (not his real name) observed an incident where one of his colleagues failed to properly de-escalate a situation with a patient on a mental health ward. His colleague Nurse Brown (also not her real name) alleged that she had been assaulted by a patient and called the Police. The Registrant witnessed this incident and provided a brief factual report about the incident on the electronic record at the end of his shift. He was the next most senior nurse on shift. As his colleague had reported the assault to the police – he was asked to provide them with a statement. A few days after the request was made, he sent an email to the Ward Manager saying he wanted his name to be removed from the list of witnesses for the police – he said 'the statement that I give would not help [Charge Nurse Brown's] case as I did have concerns for the events of the shift/period in question'. He added 'I feel that I should be supportive to team members, and support their case. Please could you advise the most appropriate course of action…'. He was told that he needed to co-operate with the police and if he had any concerns, he should discuss those with the Ward Manager. He didn't do that. In a supervision session he said what he had seen – Nurse Brown was standing on a sofa, jumped onto the back of the patient and held her in a headlock, and she had been verbally abusive to the patient. He was told to write a statement based on those facts.

Go forward five months and the Trust brings disciplinary action against Nurse Jones. At this point he said, he gave his full account. He had seen Charge Nurse Brown jumping on the back of her patient and holding her [the patient] in a head lock on 22 April 2011; he had advised her to use the correct de-escalation procedure; Charge Nurse Brown had confronted her patient and was hit with a hairbrush as a result. He reported also that many of the staff on duty had witnessed Charge Nurse Brown holding the patient incorrectly.

Kisha Punchihewa | Head of Legal

The Trust Investigator spoke about the considerable difficulties in eliciting information, let alone reliable information from staff – she spoke about a collusion of silence. This example shows that workplace culture can influence a professional's candour towards patients. In this case the Court described what the registrant did as a "crisis of conscience" and that he had a misplaced sense of loyalty to Charge Nurse Brown which may have prompted him not to speak out and so avoid getting her into trouble and that he was not prepared to give a partisan or partial account of what he saw to the police.

## Why does this matter?

In another appeal where two nurses lied to their employer and the Coroner about the treatment they had provided to a mental health patient following his death by suicide, the Court said:

'The purpose of the Trust's investigation was to learn lessons from Patient A's death so that steps could be taken to avert similar problems in the future. It was therefore critical (and ought to have been obvious) that those giving evidence to the investigation should be candid. Anything other than candour would undermine the purpose of the investigation.'

In some of the work we have done on this topic, there has been some discussion about not knowing what candour means but that seems difficult to believe. A toddler knows when they have done something they shouldn't have – they may have difficulty telling the truth about it but I would hope that an adult working in a field where their role is to care for and protect patients knows better. I recently heard it described as kindness and telling the truth – that seemed to chime with the audience. So perhaps we need to refer to it as 'being candid – telling the truth'. Mistakes will happen – our healthcare professionals are human beings not robots. But unlike robots our healthcare professionals need to learn from their mistakes and also uphold the trust that the public has in them.

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## Being open when things go wrong – an ethically embarrassing debate?

**Dinah Godfree | Policy Manager**

***'The way in which the Trust handled the matter can be viewed as an object lesson in how the tragedy of an avoidable death can be exacerbated by inappropriate handling of the case. It demonstrates the sad fact that, for all the fine words printed and spoken about candour, and willingness to remedy wrongs, there lurks within the system an institutional instinct which, under pressure, will prefer concealment, formulaic responses and avoidance of public criticism.'***

These are the words of Robert Francis QC, in **his report** on the serious failings at the Mid-Staffordshire NHS Foundation Trust, published in 2013 (the sentence underlined is our emphasis). They refer specifically to the case of a previously fit young man, who died from an undiagnosed ruptured spleen following a mountain-bike accident. An internal report found that his death would almost certainly have been avoided if a more thorough examination had been carried out when he presented himself to A&E. But this report was neither sent to the coroner, nor disclosed to the family. The pain that his family went through was exacerbated by these actions, and by further reluctance by the Trust to admit any wrongdoing.

Robert Francis was not the first to highlight failings in openness and honesty with patients and families when care has gone wrong. The **Kennedy Report** into the failings at Bristol Royal Infirmary called for the introduction of a duty of candour: 'when things go wrong, patients are entitled to receive an acknowledgement, an explanation and an apology.'

That was nearly 20 years ago. Why are we still engaged in what was described by Leape and Berwick in 2005 as an 'ethically embarrassing debate', when being open and honest about mistakes is so obviously the right thing to do?

Dinah Godfree | Policy Adviser

## Why is it hard to be open when things go wrong?

In 2013, we at the Professional Standards Authority **studied the literature on candour, disclosure and openness** to try to understand where the barriers lay to professionals either reporting their own errors or enabling others to do so. In 2018, we carried out **further research** to understand whether professional regulators had made any headway in encouraging professionals to be candid when care had gone wrong. What we found across both pieces of work was a complex and persistent set of social, cultural, psychological, and practical barriers.

## It's not my responsibility – someone else will report it

One of the main psychological barriers is 'bystander apathy' – in our context, this can be described as the diffusion of responsibility that arises where a number of people are involved in, or aware of, an incident and subsequent failures to report it or be open about it – usually resulting in no one taking action. Combined, perhaps, with a hierarchical deference that means some professionals take the lead from those higher up the chain – more on this below – this kind of apathy is likely to play an important part in the non-disclosure of incidents, particularly if it is not clear who can or should report an incident.

## A workplace culture where standards start to slip

Attitudes to openness may be specific to professions, or groups within professions – though it should be noted that at the time we carried out our literature review, most of the research related to doctors. For doctors in high-risk branches of medicine, such as surgery and anaesthetics, suboptimal, uncertain, and dangerous situations may become normal features of care. These doctors become less sensitive to abnormal care incidents, and are therefore less likely to identify, respond to, and learn from them. What is striking here is the obvious read-across to care settings with low standards of care – if incidents of poor care become normalised, this is likely to be accompanied by a loss of sensitivity about what counts as an incident worth reporting. This is supported by analysis of the Space Shuttle Challenger disaster, which found that there had been a 'normalization of deviance', in which incremental deviations from normal procedures were accepted, despite their resulting in standards that would not have been tolerated if the slippage had happened suddenly.

## Not wanting to own up to mistakes because others may think I am incompetent

Other studies suggest that there is, for some doctors at least, an expectation that medicine is an exact science that can be practised flawlessly. This means that error is considered a sign of incompetence, and psychological defences are developed to avoid classifying incidents as errors, or to diffuse responsibility for them. The fear of being judged by one's peers for making a mistake – if you believe that everyone else is flawless and will judge you for your error – is likely to be a significant barrier to openness in itself, and a problem that is somewhat self-perpetuating.

We did see some research with nurses that showed perhaps a greater willingness than doctors to be open about incidents, but the effects of this may be undermined by a deference to professionals of perceived higher status. Some nurses reported developing strategies for encouraging more senior colleagues to disclose, such as confronting them directly, or suggesting that patients ask them themselves. It seemed from this that there was not necessarily a shared expectation between doctors and nurses about what to disclose and when, and that this could create tensions and impediments to open reporting.

## A toxic workplace where a culture of blame thrives

But perhaps the most significant barrier to the disclosure of incidents is the fear of what this might mean for yourself as a professional, and your career. So much of this stems from workplace culture – how do you expect your colleagues, both clinical and non-clinical, to respond to finding out about an incident? Are you supported to be open and honest by the people and structures in place (including compliance with the statutory duty of candour

placed on NHS providers in England and Scotland, with plans for similar duties to be introduced in Wales and Northern Ireland) – or on the contrary discouraged, either explicitly or in more subtle ways? What do you know of what has happened to others in this situation? Do you fear medico-legal action, or possible consequences for your indemnity insurance?

This last question is crucial. The UK, like the US, has embraced the tort system, under which individuals are legally liable for their actions as professionals. In contrast, countries like Denmark and New Zealand have adopted a no-fault approach to compensation. There are though some misconceptions in this country about litigation in this area, and what it means for indemnity insurance. Within the NHS, **there is clear guidance** that being open is the right thing to do, and should not prejudice any future litigation. However, this may still not be fully understood, and there continue to be mixed messages about the possible impact on the cost of indemnity. Research suggests that staff take the lead from their employers on this: managers in the US who took part in a widescale survey in 2002 were twice as likely not to disclose preventable harm if the hospital itself has concerns about the malpractice implications of disclosure. This is therefore another area where employers exert influence.

## How can we overcome these barriers?

What is striking about these barriers to openness is how familiar and relatable they are to people even outside healthcare. We are most of us motivated by wanting to do the right thing, but before doing so, we tend to assess the impacts on our own lives of taking a particular course of action. Without even thinking about it, we might carry out a rudimentary cost-benefit analysis of even relatively trivial actions, such as reporting that we've clipped the wing mirror of a parked car, or challenging someone's antisocial behaviour on public transport. Is it worth the costs to me? What will it achieve? We may also find ourselves looking for reasons to justify a decision not to act.

Health and care professionals are bound by a professional duty of candour, as set out by their professional regulator – this should be an important motivating factor, that in a perfect world would eliminate the need for a cost-benefit analysis. Should I be open about what happened? Yes. *Why? Because it is your duty as a professional and it says so* ***here***. It should also act as an enabler insofar as it can be used to justify to others a decision to be open.

But of course, professionals are humans with complex motivations and fears, and they operate within complex systems alongside other humans. Where the mere existence of this duty (and potential consequences if the professional is reported to the regulator) fails to bite is if the influence exerted by barriers to openness is greater than that exerted by the professional duty combined with their personal drive to do the right thing.

Addressing these barriers is a sector-wide challenge. Indemnity providers could do more to reward candour and punish its absence. Employers can play a huge part in reducing the disincentives, and in reassuring professionals that not only will they not face unfair negative consequences in being candid, they will also be actively supported in doing so. This is part and parcel of what is often referred to as a learning culture, as set primarily by those at the top of organisations – a topic too vast to explore in more detail here. The statutory duty of candour for NHS providers, along with other initiatives such as the **Health Safety Improvement Board in England** (which we have expressed some reservations about) aim to improve responses to incidents as well learn from them.

Alongside this, regulators have made progress in encouraging candour, not least through working together on a **joint statement**. However, they still could place greater emphasis on the importance of candour in their fitness to practise proceedings, and educate their registrants on what it means and why it matters, reinforcing the messages at every opportunity, including through revalidation.

Dinah Godfree | Policy Adviser

There is also an important role for pre-qualifying education to equip future professionals to deal with the mistakes they will inevitably make, and develop the moral courage that they will need to do the right thing in the face of adversity. None of this represents a solution on its own, but it would be a significant step in the right direction.

# The professional duty of candour: widening the lens

Annie Sorbie | Lecturer in Medical Law and Ethics
Zahra Jaffer | PhD Candidate
University of Edinburgh School of Law

Annie Sorbie and Zahra Jaffer discuss that momentum needs to be maintained on embedding the professional duty of candour in healthcare professionals, but we also need to widen the lens beyond individual interactions and direct attention to the wider context in which healthcare is provided. Annie worked with the Authority to facilitate discussion groups with staff from regulators and fitness to practise panellists for our recent report *Telling patients the truth when something goes wrong - how have professional regulators encouraged professionals to be candid to patients?*

16 April 2019

Across healthcare there has been a renewed focus on the need for healthcare professionals to be open and honest when something has gone wrong with patient care (this was highlighted in in the latest blog by Michael Warren). As recently as January 2018 the report of the **Hyponatraemia Inquiry** of Northern Ireland identified repeated failures in openness and honesty. The Professional Standards Authority's 2019 Report – ***Telling patients the truth when something goes wrong*** – reflects its continued commitment to reviewing how the duty of candour has been embedded – and indeed enacted – in the wake of events at **Mid-Staffordshire Foundation Trust** and following the regulators' **joint statement on candour** in 2014.

## Maintaining momentum

In this blog we consider some of the work that has been done to continue the momentum created by the 2019 Report. In particular we reflect on insights from the Professional Standards Authority's annual academic conference and our **joint interactive workshop** on the duty of candour that we delivered at that event. We also consider how widening the lens on candour – for example by looking at research and initiatives across professions, sectors and jurisdictions – can provide valuable lessons for the implementation of the duty of candour as it is translated from policy to practice.

## What is it to be a good regulator?

The central question of the Professional Standards Authority's 2019 academic and research conference, held last month, asked: what is it to be a good regulator? The programme, curated in partnership with Professor Deborah Bowman (St George's, University of London), explored the myriad challenges and opportunities of achieving 'goodness' and provoked varied and thoughtful responses.

To those of us who have been working on the duty of candour it was striking how strongly these presentations and discussions resonated with the key themes of the 2019 Report. For example, Dr Suzanne Shale, Clearer Thinking, and Sharon Burton, General Medical Council, underlined the importance of creating compassionate workplace cultures and the link between positive workplaces and better patient outcomes, a recurrent theme across both days. In our consideration of the factors that can encourage or discourage candour in the 2019 report, we too had found that 'toxic workplace environments with a blame/defensive culture are not places where openness, honesty and transparency will thrive'. Fiona Browne, General Osteopathic Council, spoke about the need to embed professional standards into healthcare professionals' everyday practice. This again echoed our findings on the need to bridge the gap between regulation and policy,

Annie Sorbie | Lecturer in Medical Law and Ethics
Zahra Jaffer | PhD Candidate

on the one hand, and practice on the other. The conference also offered broader insights to the value and contribution of academic research to regulation at the coalface, as exemplified by the work of Professor Rosalind Searle (University of Glasgow) on workplace sexual violence.

A key feature of the Authority's work on candour so far has been its focus on the operationalisation of this duty, and how it can best be communicated and embedded on a day-to-day basis. Here Harry Cayton's **presentation on governance** was particularly pertinent. He noted, amongst other matters, that '…much of what is said about good governance misses the point by concentrating on board and committee procedures rather than on the personal qualities, skills and behaviours of board members.' He elaborated further on the key role of 'thoughtful, respectful relationships'. It seems to us that the same observations might also be made in relation to the professional duty of candour. In particular, the view of the discussion group participants was that candour was something that professionals needed to 'take to heart'. Further the 2019 Report suggests that collaborative work and consistency are key to supporting professionals and encouraging candour. Harry Cayton's observations, albeit in a different context, point us back to 'skills and behaviours' and away from reliance solely on a top-down, rules-based approach to regulation.

In our own interactive workshop on the professional duty of candour we continued to benefit from participants' views on matters including how to take into account patient and carer views on candour, the communication skills required by professionals and the role of authentic apologies.

## Looking forward: next steps

Our workshop also provided us with the opportunity to introduce and seek feedback on our new research on the professional duty of candour in the context of surgery. This is being undertaken in a collaboration between the Professional Standards Authority, the Royal College of Surgeons of Edinburgh and the University of Edinburgh. This project is just getting underway and has commenced with a literature review that builds on that undertaken by the **Professional Standards Authority in 2013**. Some preliminary observations from our review are already proving interesting. It is perhaps predictable that, since 2013, there has been a growing body of literature addressing the duty of candour as a stand-alone concept.

However, we have noted that academic attention has often focused on the technicalities of the operation of the **statutory duty of candour** at an organisational level – and in particular on reporting thresholds – rather than on the professional duty of candour and the factors that underpin whether and how this is enacted. In considering the underlying factors that can encourage or discourage candour we have also looked across jurisdictions, for example to learning on 'open disclosure' practices in New South Wales, Australia. This work is ongoing and we look forward to disseminating our findings in due course, as well as tailoring these to the specific context of surgery.

## Concluding thoughts

The need for openness and honesty in healthcare is by no means a new concern, but the implementation of the duty of candour remains persistent and pressing. Our research, research across the wider regulatory and healthcare sectors, and work across jurisdictions underlines that consideration of candour is not just about interactions on an individual level. Our attention is also directed to the wider context in which healthcare is provided and the links between positive workplace cultures and better patient outcomes. Complex issues require multi-faceted responses and now is the time to widen the lens on our consideration of the professional duty of candour if we are to effect a step-change towards its full implementation by professionals.

# The professional duty of candour is a commendable principle but to what extent can regulators influence their registrants to put it into practice?

Michael Warren | (former) Policy Advisor
Professional Standards Authority

Trust is undoubtedly the basis on which any successful healthcare professional-patient relationship is going to be built. If there is a lack of trust, we cannot realistically expect patients to agree to be examined or undergo risky surgical procedures. The professional duty of candour – that is telling the truth when something has gone wrong with care – is integral to building this trust.

28 February 2019

## Background and context

The duty of candour, like many policy initiatives was borne out a crisis, by events such as those at the **Mid-Staffordshire Foundation Trust** – these often result in a push for change and UK policymakers have been focusing on how openness and honesty can be encouraged, this is usually referred to as 'candour'. In 2014, eight of the nine professional regulators published their joint statement on candour encouraging their registrants to be candid; and enforcing the professional duty of candour through fitness to practise processes.

We have previously undertaken work around candour: **advising the Secretary of State in 2013** on whether professional regulation could do more to encourage professionals to be candid. We followed this up with two further reports: one in late 2013 aimed at understanding the limits and potential for regulatory action in this area; and then in November 2014 we published a report outlining progress made on strengthening professional regulation's approach to candour and error-reporting.

## A renewed focus

We felt the time was right to renew focus on candour. We wanted to find out how far policy interventions have come in ensuring that patients can expect professionals to be candid with them. Our recent publication – ***Telling patients the truth when something has gone wrong*** is the result. Two main data sources fed into the final report:

1. discussion groups with regulators' staff (mainly staff involved in the fitness to practise process, such as panellists) – discussions were facilitated by Annie Sorbie, Lecturer in Medical Law and Ethics at Edinburgh University
2. questionnaires completed by regulators and stakeholders across health and care.

## What the report reveals

One obstacle to fully understanding the effects of regulatory interventions on candour is that it is difficult to measure candour quantitatively. How do you measure whether a workforce is more or less candid? It's even more difficult to measure whether regulatory interventions/ encouragement have made any difference. Therein lies the problem. Much of the data and detail around candour is inconsistent and stems from the qualitative nature of candour. One of the research participants highlighted that regulators are in a better position to measure the absence of candour rather than its presence. Regulators can do this through their fitness to practise processes. We need more consistency in collecting the data, the terminology used and look at candour in the wider context, not just from fitness to practise data.

Michael Warren | (former) Policy Advisor
Professional Standards Authority

### What progress have the regulators made?

The regulators have embarked on various initiatives to embed and encourage candour in their registrants during the last four years. Even with the above caveat in place (about data), the regulators have made progress. They have all pressed ahead in multiple areas to encourage candour in their registrants. They have put in place specific standards requiring registrants to be open and honest when something has gone wrong, and five of the regulators have produced accompanying guidance.

### Learn by example

However, our report also reveals that being candid is all very well in principle, putting it into practice can be more complex. Registrants can feel that their regulators are far-removed from the everyday practice of their profession, not subject to the same pressures they face. Questionnaire answers suggested that regulators need to show rather than tell their registrants how to be candid and bring the duty of candour to life. Case studies can provide guidance to registrants based on real-life situations they may find themselves in or, at least, be familiar with.

The Nursing and Midwifery Council (NMC) has produced a number of **case studies** to help its registrants with the duty of candour, what it means for their practice and how to meet it in a range of scenarios. Other regulators have included specific sections on candour in their indicative sanctions guidance as part of their fitness to practise process.

### A proactive rather than a reactive approach to candour

Fitness to practise though is reactive and usually involves an incident where candour is absent rather than present. It could be possible therefore to gauge the absence of candour's impact on patients and professionals, but not the benefits of professionals being candid. It is also not possible from the fitness to practise data to set the scene. What was the wider context? Is candour absent in the individual healthcare professional or does the place where they work inhibit candour? If so, what are the wider implications for patient safety in this particular organistion?

### Telling patients the truth - factors to encourage

For patients to really benefit, we need to switch to a more proactive and preventative approach to embedding candour. Regulators need to cooperate with education and training providers to raise awareness about the professional duty of candour to trainees/students and those professionals at the start of their career. Education and training can play a pivotal role in this and regulators have made moves to embed candour, for example, by:

- introducing education and training provider standards which specifically mention candour
- speaking directly to trainees and students to flag and discuss candour issues
- through continuing professional development/revalidation.

### Communicating with their registrants

Regulators have also encouraged candour by engaging directly with their registrants. This can be through newsletter articles, short animated videos, training sessions and advice lines, as well as working with stakeholder organisations such as system regulators.

This figure (below) provides an overview of the regulatory tools in place to help registrants understand candour (and can be found on page 31 of the report).

Michael Warren | (former) Policy Advisor
Professional Standards Authority


## Where do the regulators go from here?

### Turning a negative into a positive

Candour is currently viewed and discussed from a more negative angle – usually where there has been a lack of candour, especially as part of a fitness to practise process. Many questionnaire respondents/discussion group participants believed that regulators should take the opportunity to rethink their approach to candour, looking at when a professional has been candid with a patient, or 'positive' candour. Fitness to practise could provide the framework for this – as one professional body noted 'fitness to practise can be an opportunity for regulators to emphasise that candour is not just a duty to be discharged, but a quality to be sought and valued'.

### Not by regulation alone: cooperation and consistency

Regulators need to take a consistent approach to incorporating the professional duty of candour in their four core regulatory functions (guidance and standards, education and training, registration and fitness to practise), but they also need to work with other stakeholders.

As already touched on, registrants can feel a degree of separation from their regulators. The capacity of individuals to be candid is mostly influenced by their work environment. In our **2013 report**, we identified that many of the barriers that inhibit candour are in the workplace (and these barriers are still present). Regulators are not well-positioned to help their registrants overcome these barriers and need to work in concert with employers, system regulators, professional bodies and other groups who have a more direct impact on professionals' daily lives.

# The role of regulators in encouraging a Speak Up culture

Russell Parkinson | Head of Office
National Freedom to Speak Up Guardian for the NHS

‘See it Say it. Sorted’ – you usually hear this if you are taking any kind of public transport and it applies to being vigilant – keeping a look out for unusual behaviour that could put people at risk. However, you could also apply this principle to speaking up and raising concerns in a health/care setting – concerns which, if ignored, could also put people at risk. In his blog, Russell Parkinson explains that without positive and supportive organisational cultures and good leaders, staff can ‘see it’; they can ‘say it’, but it might not always get ‘sorted’.

6 November 2019

## Background

On 1 April 2017 a new legal duty came into force which required all prescribed bodies to publish an annual report on the whistleblowing disclosures made to them by workers. In September 2018, the health professional regulators published their first **joint report on whistleblowing disclosures** made to them. A year later the Authority organised a seminar bringing the regulators together to discuss the work they have been doing to strengthen arrangements to encourage a Speak Up culture.

Russell Parkinson came along to the seminar in his role as Head of Office, **National Freedom to Speak up Guardian** for the NHS. In his guest blog, Russell outlines the progress made by the Freedom to Speak up Guardians, but also underlines that for Speaking Up to be effective, there needs to be supportive organisational cultures with good leaders.

## Encouraging a culture which supports freedom to speak up

The **Interim People Plan** aims to ‘to grow the NHS’s workforce, support and develop NHS leaders and make our NHS the best place to work’. The plan says that in addition to recruiting extra staff, much more needs to be done to improve staff retention and transform ways of working. Secretary of State Matt Hancock MP has said that ‘we need …. a more supportive culture to make that plan a reality’. A positive speaking up environment where workers feel valued and listened to is fundamental to developing a supportive culture.

If it is the role of regulators to protect patients, service users and the public, then it stands to reason that they also have a role to play in encouraging a supportive culture for those they regulate.

The events at Mid Staffs and Gosport War Memorial Hospital serve as reminders of the harm that can occur to patients when a Speak Up culture does not exist. Following the publication of the ***Francis Freedom to Speak Up Review*** in 2015, Trusts and Foundation Trusts in England have appointed Freedom to Speak Up Guardians. The network has now grown to over 1,000 guardians, champions and ambassadors in NHS trusts and FTs, independent sector providers, national bodies and primary care organisations. Thousands of cases have been brought to Freedom to Speak Up Guardians since April 2017.

The National Guardian’s Office supports this network of Guardians through training, disseminating good practice, undertaking case reviews, and providing challenge and works across the system to tackle barriers to speaking up.

## What is a ‘healthy workplace culture’ and how do you measure it?

The saying ‘what gets measured, gets done’ was never truer than when faced with an

Russell Parkinson | Head of Office
National Freedom to Speak Up Guardian for the NHS

inspection from a regulator. But culture is a difficult thing to measure, despite its acknowledged importance. A healthy culture is hard to define in concrete terms, it seems vague and difficult to pin down. Culture by its very nature is what happens when nobody's looking – so measuring it seems impossible. Yet there are some indicators which can give an insight into what a Speak Up culture looks like.

In the National Guardian's Office Freedom to Speak Up Guardian Surveys, we showed that guardians in organisations rated Outstanding by the Care Quality Commission were more positive in their perceptions of the speaking up culture. We wanted to understand how other NHS workers perceived speaking up in their organisations, so we have created a single measure from four questions from the 2018 NHS Staff Survey.

The questions ask how workers feel their organisation treats staff who are involved in an error, near miss or incidents; whether they are encouraged to report these; if they would know how to report unsafe clinical practice; and if they would feel secure raising concerns about it.

By bringing these four questions together into a 'Freedom to Speak Up (FTSU) index' and comparing them with CQC overall and Well-Led inspection results, we are able to see a correlation between workers' perception of a supportive Speak Up culture and organisations which are managed well. For regulators, this is potentially a lead indicator which can be viewed together with other information about safety, workforce and culture.

## The regulators' role

Regulators also have a role to play in offering safe spaces for workers to speak up, when other internal routes may not have been successful. But it is not enough to listen to what workers have to say, it is also important to ensure that action is taken as a result. Sending the message that regulators are listening will also help focus leaders' minds that their workers voices are important. Leaders will be held accountable if they fail to promote an open and learning culture.

Creating the right workplace environment
We also need to model this behaviour in our own workplaces. We all have a responsibility to encourage an environment where candour and feedback are business as usual. A supportive Speak Up culture is one where all of us should be able speak up about anything. Where we can share ideas, seek advice, offer feedback, challenge decisions or raise concerns without fear of repercussions.

A positive speaking up culture is often associated with higher performing organisations. It is a reflection in how psychologically safe people feel, that they are able to speak up, feedback, and work together to innovate and perform effectively.

Workers are the eyes and ears of an organisation and they should be listened to when considering patient safety and experience. The best leaders understand how important this is. These leaders create an inclusive speaking up culture where everyone's insight and expertise is valued, and all workers are empowered to speak up and contribute to improvements in patient care.

Ultimately, speaking up protects patient safety and improves the lives of NHS workers. For regulators, whose role it is to bring peace of mind to the public, it is important to show that those they are regulating are listening and learning.

## Find out more/useful links

- You can find out more about or work on the professional duty of candour, including policy advice and research reports on our website - **here**
- You can find more blogs - **here**
- Find out more about all our research - **here**