Response to Department of Health and Social Care call for evidence on duty of candour review

May 2024

1. Introduction

1.1 This is the evidence submission from Professional Standards Authority (PSA) to the Department of Health and Social Care's call for evidence on the duty of candour review.

1.2 The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and registration of people working in health and care. We are an independent body, accountable to the UK Parliament. More information about our work and the approach we take is available at www.professionalstandards.org.uk

1.3 As part of our work we:

- Oversee the ten health and care professional regulators and report annually to Parliament on their performance
- Accredit registers of healthcare practitioners working in occupations not regulated by law through the Accredited Registers programme
- Conduct research and advise the four UK governments on improvements in regulation
- Promote right-touch regulation and publish papers on regulatory policy and practice.

1.4 We have considered the consultation questions from the perspectives of our sector – the regulation and registration of health and care workers, and regulation in health and care more generally. We have commented on those where we think we have a useful contribution to make.

2. Detailed comments

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

2.1 As evidenced by recent Inquiry reports, lack of candour and openness remains a significant problem within the healthcare system. In our 2022 report *Safer care for all,* we described 'the pattern of almost systematic lack of candour uncovered by public inquiries', listing the Kennedy Inquiry into failings at Bristol Royal Infirmary, the Francis Inquiry into failings at Mid-Staffordshire NHS Foundation Trust, the Hyponatraemia Inquiry in Northern Ireland, the Paterson Inquiry, the Kirkup Inquiry into failings at Morecambe Bay, and the Ockenden Review into failings at Shrewsbury and Telford Hospital NHS Trust. (Safer care for all, p69)

2.2 The importance of candour continues to be highlighted in high-profile reports. Only last week, the report of the Infected Blood Inquiry stated that "*candour is essential in the relationship between clinicians and patients. Both patients, in accepting treatment, and clinicians, in advising on it, are badly affected by its absence*" (Infected Blood Inquiry Report, volume 7, page 214).

2.3 While the healthcare failings described in the Infected Blood Inquiry are largely historical, the same cannot be said of the Birth Trauma Inquiry, which found that a lack of candour continues to be a feature associated with poor maternity care. As the report notes "*it is clear that the statutory duty of candour, introduced in the wake of the Francis report, is not being applied effectively*" (Birth Trauma APPG, Birth Trauma Inquiry Report, page 21).

2.4 In our role overseeing ten professional health and care regulators, we are witnessing what appears to be an increase in the number of cases relating to a lack of candour. This does not necessarily mean that the problem itself is growing – it may be a consequence of changes in the way regulators themselves are operating, and more work would need to be done in order to draw any firm conclusions. The case numbers do however seem to confirm that the persistent nature of this problem.

2.5 The reasons for this are undoubtedly complex, and linked to organisational culture. Professionals may be reluctant to be open and honest as a result of factors such as a fear of retribution from employers, professional protectionism, and psychological barriers. This has been highlighted by Sir Brian Langstaff, where he reiterated that the "*failure to bring the true facts to life has come partly from the inertia of groupthink; but partly, it must be recognised from instinctive defensiveness, to save face and to save expense*." (Blood Inquiry Report, volume 7, page 297). In 2013, the PSA published research into the barriers to openness, which still has currency (https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/candour-research-paper-2013.pdf?sfvrsn=5b957120_8).

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

Please provide your views, evidence or experience as part of your feedback.

2.6 Although we acknowledge that this consultation's primary focus is on the statutory organisational duty of candour, we would like to use this opportunity to emphasise the importance of considering the professional duty alongside the organisational duty. As outlined in the written evidence that we submitted to the House of Commons' Social Care Committee Expert Panel on the Evaluation of the Government's progress on meeting patient safety recommendations, health and care professionals must comply with both duties and it is important to consider why the duties may not be embedding as expected or hoped, as the barriers to openness are multiple and complex

(https://committees.parliament.uk/publications/44002/documents/217961/default/).

2.7 We urge the DHSC to consider the role of the professional duty when evaluating the responses from this consultation.

3. Further information

3.1 Please get in touch if you would like to discuss any aspect of this response in further detail. You can contact us at:

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