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Shared Insights

Duty of Candour

Panel of speakers

Carl May-Smith – Barrister and Partner, Browne Jacobson
Amanda Oates – Chief People & Culture Officer / Deputy Chief Executive, Non-Clinical Services, Mersey Care NHS Foundation Trust
Jacqui Atkinson – Partner and Head of Employment Healthcare, Browne Jacobson

NHS
Mersey Care
NHS Foundation Trust

Browne Jacobson

Introduction

During this session, we reviewed the recently published findings by the Department of Health and Social Care regarding the call for evidence on the statutory duty of candour.

Amanda Oates, Chief People & Culture Officer / Deputy Chief Executive – Non-Clinical Services at Mersey Care NHS Foundation Trust, presented her insights on achieving organisational culture change from Board level to ward level, highlighting the significance of psychological safety for staff to speak candidly and openly when things go wrong.

Additionally, we examined the government's proposals to introduce a professional duty of candour for NHS Managers, discussed potential future regulations, and considered their possible impact.

Contents

How we can help

Our team at Browne Jacobson comprises lawyers with specialist knowledge and expertise in the duty of candour and related legislation and guidance. We are well-equipped to assist healthcare providers in navigating the complexities of these requirements, offering tailored advice and practical solutions to ensure compliance and to promote a culture of openness and transparency.

In particular we can provide:

- Responsive duty of candour advice for senior leadership teams, Registered Managers and clinicians.
- Duty of candour training.
- Bespoke policy and template document drafting or review.
- Training on the management of concerns received about the Board and how to handle those concerns under the NHS framework of policies available and the Fit and Proper Persons framework.

If you or your organisation would like to discuss any of the above, please do get in touch.

Duty of Candour: Where are we now?

Carl May-Smith – Partner (Barrister), Browne Jacobson

Carl began by reviewing the Department of Health and Social Care's findings on the call for evidence on the statutory duty of candour. Not only was there a lack of confidence that the duty of candour is well understood and complied with, but there was also a stark difference between the perception of patients and professionals regarding whether providers have engaged compassionately with the duty. A predominant theme from the findings was the culture within the health and care system, which impacts the effectiveness of the duty of candour. Additionally, two other significant themes emerged: inconsistency in understanding and applying the duty, and the need for further training.

Carl pointed out that while creating policies and guidance documents about the duty of candour is relatively straightforward with the right support, providers often struggle with implementation and consistency of compliance. Staff and resource shortages can be a factor, whilst also hindering professionals from undertaking comprehensive training. Computer systems do not always promote compliance or simplify record-keeping associated with the duty of candour.

However, these practical issues are secondary to the prevailing cultural barriers. Despite assurances that saying "sorry" does not equate to admitting liability, concerns about liability and blame persist. The duty of candour is sometimes perceived as a technical or legal obligation rather than a natural extension of the great care staff already aim to provide.

There can also be a misconception about the time required to adhere properly to the duty, along with a lack of understanding of or buy-in to its purpose. This can engender resentment amongst frontline staff that may contribute to a perceived lack of compassion or engagement.

Addressing the duty of candour therefore requires a multifaceted approach that not only tackles practical challenges but also fosters a supportive culture of openness and understanding.

Resources:

- Key findings: Call for evidence on the statutory duty of candour.
- Findings of the call for evidence on the statutory duty of candour - GOV.UK.
- Duty of candour and insurance: Navigating medical liability.

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Achieving a culture of candour – the Mersey Care experience

Amanda Oates – Chief People & Culture Officer / Deputy Chief Executive, Non-Clinical Services, Mersey Care NHS Foundation Trust

Amanda Oates is the Chief People & Culture Officer / Deputy Chief Executive – Non-Clinical Services at Mersey Care NHS Foundation Trust (a mental health and learning disability trust). She shared insights from her experience at the Trust and its efforts to cultivate a culture of candour.

Amanda posed a question to delegates regarding the factors that influence practitioners' ability to be candid. The overwhelming response was the fear of repercussion and blame. Amanda agreed but emphasised that blame is unhelpful and detrimental to everyone, including service users and families. Despite the numerous NHS frameworks in place designed to mitigate a retribution culture, blame still prevails. It is easy to fall into negative, blameful language when an incident occurs, however, it significantly affects candour. If professionals don't feel psychologically safe, they are unlikely to be as candid as they possibly can when something goes wrong. They won't feel that they will be listened to, understood or supported. The safer staff feel, the more open and honest they will be. Psychological safety is very powerful.

Amanda recounted a period at the Trust during which several patient suicides occurred. In response, the Trust conducted numerous reviews and suspended many staff members. They initially believed that an insurance-driven approach and holding individuals to account was appropriate. However, upon reviewing employee relations data, the Trust recognised that it had applied its processes unfairly, causing harm to its employees in the process. Providers need to reflect on whether their policies are defensive and divisive and causing harm to their people.

The Trust identified that the fear of blame was the main barrier to candour. They considered how they could change their approach to better support and understand individuals after an event has occurred.

The Trust realised that, during incident investigations, investigators might assume they know how to perform a person's job without having actual experience in that role or of the team dynamics or the environment in which the incident occurred. Further, it is important to reflect on causation and contribution together, and to consider what systems and processes may have contributed to the incident – staffing levels, handover, training etc. The focus should be on the "what" and "why" rather than the "who". Candour is affected if we immediately go to retribution, rather than understanding who was hurt and how those people are going to be supported post event.

Amanda suggested that if individuals do not provide the truth or a complete account of events, providers need to consider why. Often, it is due to a lack of trust in their employer, and fear that telling the truth is going to lead to retribution and blame. However, all the data indicates that blame is unproductive, has economic consequences, limits learning and fails to prevent future deaths. Organisations need to be prepared to listen. Achieving the right culture, civility and respect will lead to success.

Encouraging a "just culture" within teams is essential. Without it, candour and openness fall apart. There needs to be diversity of thought and opinion within teams. Managers should be encouraged to receive feedback on their style or approach, and to sit and reflect on that feedback rather than react defensively to it. Could their leadership, and the team's culture, be enhanced by using different language? A lack of feedback for a leader isn't a positive sign, as it often indicates staff do not feel safe to speak up.

Managers need to consider how they react to an incident, as the initial response can be the biggest determinant of how candid people are. There is power in a "pause" – pausing before responding.

Amanda highlighted the importance of language. Asking why an individual did something wrong can create fear and a reluctance to speak up. Silence is an indicator of a closed culture. Individuals need to be particularly aware of their biases, which are inherent within us. It's imperative to think about biases when approaching and listening to staff.

Key Takeaways:

- Encourage a supportive and open culture to enhance the duty of candour. Focus on understanding the "what" and "why" rather than assigning blame.
- Psychological safety is essential to enable staff to be candid.
- Think about the preparation before, the conversation in the middle and how you will work towards a solution. How will the organisation learn from an adverse event?
- It's important to set the right tone for candour. Don't ask questions like, "why did you get that wrong?" "Why didn't you follow the rules?" "Why did you do that?"
- Diversity of thought and constructive feedback are essential for a "just culture".
- Be aware of biases and their impact on interactions with staff.
- Consider the initial response to incidents carefully; a pause can be powerful.
- A restorative culture is not a destination, but rather a state of mind.

Key / suggested resources:

- Just Culture: The Movie – This documentary tells the story of Mersey Care NHS Foundation Trust and how it changed to a 'just and learning culture' to implement restorative justice in the aftermath of incidents and harm. https://youtu.be/SHU6TUjGg14
- "Just Culture: Balancing Safety and Accountability" by Sidney Dekker
- Amanda will shortly be leaving Mersey Care NHS Foundation Trust to set up her own consultancy, Cultivating Restorative Cultures. Amanda can be contactable at: Amandajoyoates@outlook.com

Future regulation of NHS Managers

Jacqui Atkinson – Partner and Head of Employment Healthcare, Browne Jacobson

Jacqui emphasised the importance of having a "speak up" system. She has been involved in several NHS cases where serious issues were raised, and where the focus was on the "who", which in turn can influence the organisational response.

In one instance, there was an immediate doubt about the validity of the concerns raised due to the focus on who had raised them.

The attention must be directed towards understanding the “what”, “how, where, when” and “why” rather than concentrating on the “who” in the initial speak up phase. Naturally, if matters need to progress into formal investigations under other policies (such as Dignity at Work or Disciplinary) then the “who” becomes more of a relevant issue.

There has been a lot of discussion about the future regulation of NHS Managers, due to the findings of numerous high profile public health inquiries over the past few years, such as the Francis Inquiry, the Infected Blood Inquiry and the current emphasis on the role of NHS senior managers in the Thirlwall Inquiry. One of the recommendations from the Infected Blood Inquiry was to extend the duty of candour to cover individuals in leadership positions in NHS organisations, including board members. These individuals would then be required to record, consider, and respond to all potential patient safety problems, and should be held personally accountable for any failure to do so. The suggestion is that the current system we have is not working due to a lack of regulation at senior level.

A government consultation was recently held regarding proposals to regulate NHS managers in England and responses were invited to a series of questions and issues. Given what has come out of other Inquiries and the current focus on senior managers, we have to wonder whether, given other professionals such as doctors and nurses are regulated and subject to sanctions for non-adherence to codes of practice, the growing view that senior managers and board members should also be subject to regulation will be introduced. Anyone could respond to the consultation, which ran until the 18 February 2025. Feedback on the consultation is now being analysed and the outcome will be published by the government in due course.

Several options are under consideration, including a statutory barring system, which would list individuals who have committed offences and are prohibited from holding certain positions. The Teaching Regulation Agency operates such a system. A professional register and voluntary accreditation route has also been suggested, operating in a way similar to the regulation of doctors by the General Medical Council. The consultation is also looking at which managers should be regulated, how revalidation will operate, which body should take responsibility for the regulatory system and what professional standards should be implemented.

Jacqui observed that Boards may occasionally face challenges in addressing significant concerns when they arise, particularly when managers and senior figures are concerned, and judgment calls are made about whether to act or not which is a fact based decision.

However, if an obligation to act is established, Boards will be better prepared to engage in those challenging discussions with colleagues and to apply the approach as set out in the Regulations consistently.

Browne Jacobson will continue to provide further commentary on the regulation of NHS Managers as the consultation process progresses.

Key takeaways:

- It is crucial to have a "speak up" system, which focuses on the issues raised rather than on who raised them or who are the concerns are about.
- There is ongoing discussion about the future regulation of NHS Managers driven by findings from inquiries like the Francis, Thirlwall, and Infected Blood. The Infected Blood Inquiry recommended extending the duty of candour to include NHS leaders and board members, making them personally accountable for patient safety issues.
- A government consultation ran until 18 February 2025, inviting responses on how to regulate NHS managers in England. Options under consideration include a statutory barring system, a professional register and voluntary accreditation scheme.
- The consultation seeks to determine the scope of regulation, revalidation processes, responsible regulatory bodies, and professional standards for managers.
- Establishing an obligation to act will possibly help Boards address significant concerns more effectively.
- Browne Jacobson will continue to provide updates on the regulation of NHS Managers as the consultation progresses.

Resources:

- Leading the NHS: proposals to regulate NHS managers - GOV.UK
- Guidance for chairs on the implementation of the Fit and Proper Person Test for board members
- Freedom to speak up policy for the NHS – an NHS England model policy which should be adopted by all NHS organisations.

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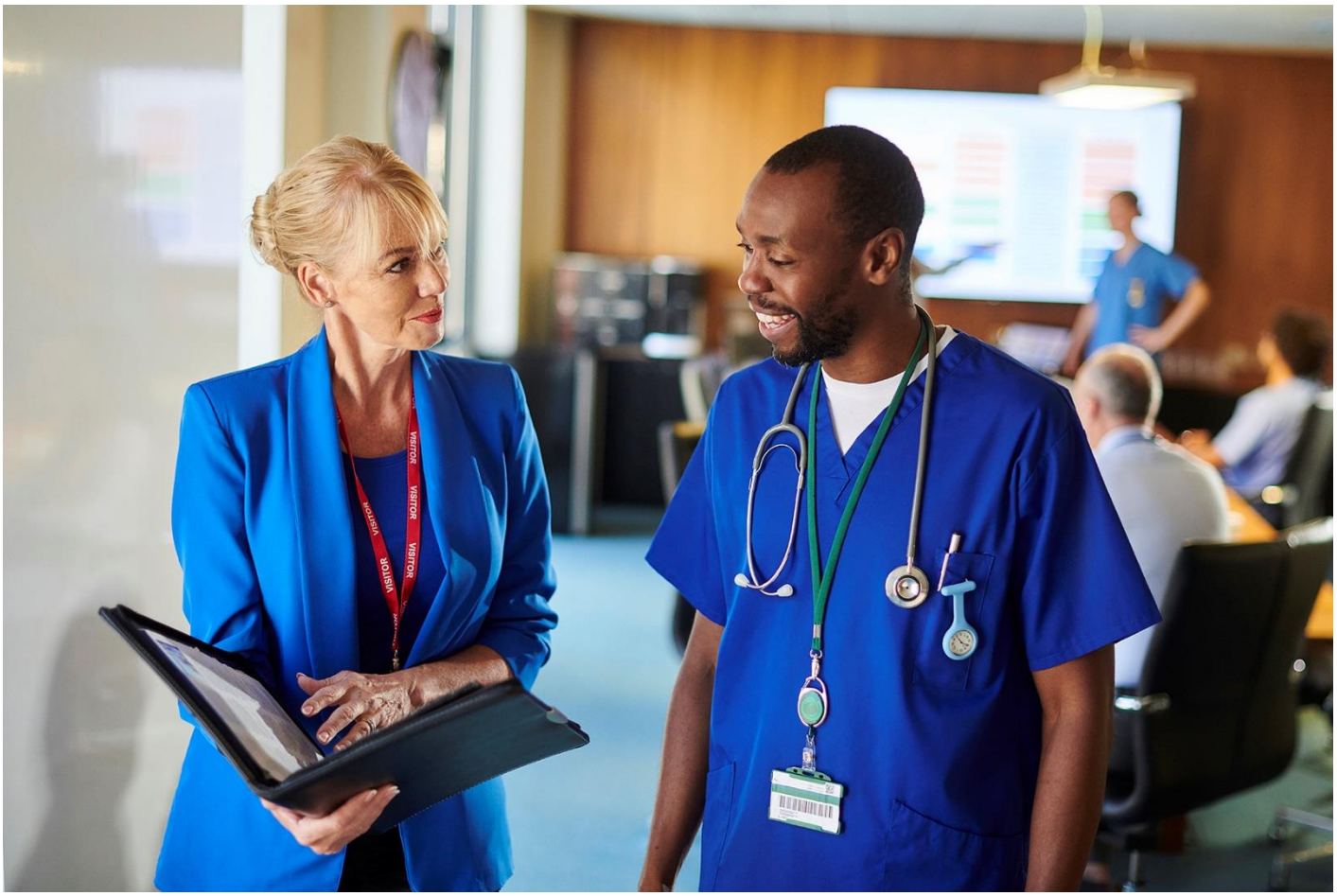

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