The Forum of Complex Injury Solicitors (FOCIS)

Response to Consultation on Statutory Duty of Candour – May 2024

Response to the Department of Health and Social Care (DHSC) Consultation on Statutory Duty of Candour

About FOCIS

About Us

FOCIS members act for seriously injured Claimants with complex personal injury and clinical negligence claims, including group actions. The objectives of FOCIS are to:-

1. Promote high standards of representation of Claimant personal injury and medical negligence clients;

2. Share knowledge and information among members of the Forum;

3. Further better understanding in the wider community of issues which arise for those who suffer serious injury;

4. Use members' expertise to promote improvements to the legal process and to inform debate;

5. Develop fellowship among members.

See further www.focis.org.uk

Membership of FOCIS is intended to be at the most senior level of the profession, currently standing at 25 members. The only formal requirement for membership of FOCIS is that members should have achieved a pre-eminence in their personal injury field. Eight of the past presidents of APIL are members or Emeritus members of FOCIS. Firms represented by FOCIS members include:

Anthony Gold	Hugh James
Ashtons Legal	JMW
Balfour + Manson	Irwin Mitchell
Bolt Burdon Kemp	Leigh Day
Dean Wilson	Moore Barlow
Digby Brown	Osbornes Law
Fieldfisher	Serious Law
Fletchers	Slater and Gordon
Freeths	Stewarts

Hodge Jones & Allen

Switalskis

Thompsons NI

Consultation on duty of candour

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

   Neither agree nor disagree

   Please provide your views, evidence or experience to explain your answer. (Maximum 500 words)

   We believe that the purpose of the duty is clear. We cannot comment on whether it is well understood by those NHS Trusts and other bodies the CQC regulates as our members do not act for those bodies. However, we would expect it to be since this legal duty has existed since 2014 for trusts and 2015 for other providers.

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?**

   Disagree

   Please provide your views, evidence or experience to explain your answer. (Maximum 500 words)

   We would expect all registered healthcare professionals to be aware of their duty and the need for openness and transparency where patients have been put at risk or suffered harm.

   We believe however, given the numerous reports on serious care failings, cover ups and the treatment of whistleblowers that there is a pressing need to improve organisational understanding and compliance so that staff can raise concerns without fear and so that patient safety incidents are properly reported.

   There has long been a recognised need for a cultural shift in the NHS away from one of blame and denial to one of active listening and learning. The duty of candour not only underpins this but should also lead to improving patient safety.

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

Disagree

Please provide your views, evidence or experience to explain your answer. (Maximum 500 words)

Whilst we are now seeing more 'duty of candour' letters than a few years ago our members tell us that they are still meeting with many patients or families who have not been told about notifiable safety incidents despite the statutory duty of candour.

By way of example:

- The family of a baby who died 3 days after birth after failures to escalate the mother to a doctor, failure to transfer the mother to theatre for an emergency caesarean section and a failure to act on the baby's blood results, all identified in a report by HSIB. They have been offered no explanation, no apology and have received no duty of candour letter from the Trust.

- A man whose previous scans revealed brain tumours, which although seen on the scans had gone without action until he suffered seizures. The only treatment now available is palliative care. Although the three Trusts are now aware of his diagnosis and he has made a written complaint none of the Trusts involved in his care have complied with the duty of candour.

- A man who underwent a circumcision in which too much skin was removed. When he raised concerns with the hospital he was referred to a urologist at another hospital – no apology and no explanation given. The records of the procedure are not available. NHSR have just admitted liability but he has not received any communication from the Trust.

There are too many other examples to list here. Suffice to say there are so many that it is absolutely clear to us that the statutory duty of candour is regularly and repeatedly not being complied with by the vast majority of Trusts.

Having said that, our members report evidence that some Trusts do comply and communicate well with families and there are examples of good practice, that could and should be replicated across the NHS as a whole. It seems to us that these tend to be Trusts which have experienced significant incidents that have affected large numbers of people and they are under external pressure (regulatory, public, group civil claims etc) to explain and improve the service, for example Nottingham University Hospital NHS Foundation Trust due the failures in their maternity services. It seems with external scrutiny these Trusts have been able to ensure good compliance with the statutory duty of candour.

However, in our experience those under less scrutiny still seem to have an attitude of 'hiding' such incidents, in particular from the patient/family, unless or until that patient or family proactively seeks answers and, even then, those answers are only given once lawyers become involved.

Were compliance with the statutory duty of candour being effectively regulated then we would expect data to be available from the regulator to inform this consultation. In the absence of that, we would suggest a useful source of data would be NHS Resolution's record of cases in which admissions of liability were made. It would be interesting to know in how many of those cases the statutory duty of candour had been complied with at the time of the incident giving rise to the claim.

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.

   Disagree

   Please provide your views, evidence or experience to explain your answer. (Maximum 500 words)

   Our members' experiences are variable and thereby, the overriding concern is one of inconsistency of approach between providers. The right culture is essential to promote openness, transparency, honesty, and empathy in these circumstances.

   There are certainly examples where Trusts do engage meaningfully with patients and their families, but this has often been developed in response to a large cohort of patients suffering harm. For example, Nottingham University Hospital (NUH) NHS Trust was served with an enforcement notice by the CQC in December 2020; has been fined £800,000 for the admitted failings in the care of Wynter Andrews and its' maternity services are now the subject of an independent review by Ms Ockenden with nearly 2000 families are involved. The Trust have undoubtedly improved its' communication and engagement with patients and families as a result.

   The key is culture, education, and learning. The priority has to be improving communication and training for those who are involved with having to discuss failings in care with patients or their families. Providers should not be afraid to apologise (this is not an admission of liability.) Conversations need to be brave, tailored, and meaningful. Patients and their families are primarily seeking an explanation, apology and reassurance that lessons will be learnt to prevent harm in the future.

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

   Disagree

   Please provide your views, evidence or experience to explain your answer. (Maximum 500 words)

We have a number of concerns about two of the criteria.

We question the use of the word ‘unintended’. Whilst we assume this was included so that any harm caused as a necessary result or side-effect of reasonable treatment was not notifiable, unfortunately in the last few years there have been a small but significant number of healthcare professionals intentionally causing harm, e.g. Lucy Letby, Ian Paterson. In our view the statutory duty of candour should still apply in incidents arising from such intentional actions.

We also question the subjectivity of the criteria – both in defining what was ‘unintended’ or ‘unexpected’ but also by use of the phrase ‘in the reasonable opinion of a healthcare professional’. Whilst the word reasonable adds some objectivity both causation (i.e. whether the incident caused the harm) and what is considered harm is left to an individual healthcare professional, who may be junior, inexperienced and/or whose views may not accord with the majority. We would suggest this criterion should include more elements of objectivity. For example, if could be rephrased in line with test for breach of duty in clinical negligence cases (Bolam), i.e. an incident is notifiable if a responsible body of medical opinion would consider the incident had resulted in harm.

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?**

   Don’t know

   Please provide your views, evidence or experience to explain your answer. (Maximum 500 words)

   As we do not have inside knowledge of the regulated services we do not have primary evidence of whether the thresholds are understood, but our members’ experience (as described above) suggests that the thresholds are not understood, Trusts are purposefully not complying with the duty, or there is some other impediment to compliance of which we are unaware.

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?**

   Don’t know

   Please provide your views, evidence or experience to explain your answer. (Maximum 500 words)

   As we do not have inside knowledge of the regulated services we do not have primary evidence of whether the criteria are understood, but our members’ experience (as described above) suggests that the thresholds are not understood or Trusts are purposefully not complying with the duty, or there is some other impediment to compliance of which we are unaware.

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?**

   Don't know

   Please provide your views, evidence or experience to explain your answer. (Maximum 500 words)

   We are not party to how incidents are categorised or recorded so cannot comment, other than to repeat our observations above.

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?**

   Don't know

   Please provide your views, evidence or experience to explain your answer. (Maximum 500 words)

   We are not able to comment directly in this regard but our observation would be that there have been numerous reports on serious care failings, scandals and cover ups (mid Staffs, Kirkup, Ockenden, Cumberledge, Langstaff and the imminent public inquiry into the Lucy Letby case.) Their findings in relation to the need for cultural change and similar recommendations highlight that the duty of candour, enforcement and accountability is more important than ever and needs to be properly prioritised by all providers.

   Learning needs to become embedded within the grass roots of all providers and would positively influence the healthcare system by improving patient safety and standards. Candid conversations are likely to result in quicker and simpler investigations, early admissions of liability thereby leading to prompt resolution.

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

    Disagree

    Please provide your views, evidence or experience to explain your answer. (Maximum 500 words)

    The number of instances of non-compliance of which our members alone are aware is in our view evidence that it is not effectively regulated or enforced.

    We assume that the CQC can provide information on its' regulation and on enforcement action taken since the statutory duty was brought in. If the press releases

on the CQC's website are reflective of when they last took enforcement action that would seem to be in 2019. If that is correct, we consider that speaks for itself.

We can only repeat what we have said above. Our members see numerous cases in which the duty has not been complied with. We are not aware of CQC involvement in any of those cases.

Our members' experience is that when patients or families raise concerns about the duty of candour with the CQC the regulator rarely acts.

In our view more effective regulation and enforcement is needed.

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?

Please provide your views, evidence or experience to explain your answer. (Maximum 500 words)

- A long-standing embedded culture within the NHS/Trusts and the department of health (as recently described by Sir Brian Langstaff in his report arising from the Infected Blood Inquiry) to hide the truth when it is feared it may be damaging.

- A lack of any real consequence for not being honest and open.

- A blame culture within Trusts between management and healthcare providers, senior and junior healthcare professionals, nurses and doctors and different disciplines, which discourages transparency.

- A defensive 'them v us' attitude between healthcare professionals and patients when an incident occurs.

- A lack of education and learning on the statutory duty of candour.

- A lack of protection for whistleblowers who do raise concerns about safety incidents. There are numerous reports of poor treatment by the NHS/Trusts of those medical professionals who have reported patient safety incidents by Trusts, described by those who have whistle-blown as including bullying, harassment, gaslighting and involving a loss of reputation and their career. This is obviously a real deterrent to any healthcare professional considering reporting an incident.

- A historical and ongoing lack of regulation or enforcement of the professional duty of candour. Those healthcare professionals who are now expected to report incidents are not used to 'holding their hands up' as despite the GMC and NMC imposing a professional duty of candour we see little evidence of that being enforced. This is contrary to other professions, e.g. law, where the duty to acknowledge a mistake and advise a client of their right to seek alternative legal advice is well enshrined.

- A lack of scrutiny from both Trust leaders and the regulator of compliance with the statutory duty of candour.

- A lack of enforcement of the statutory duty of candour, as described above.

- Often it is only patients or families holding Trusts to account. The imbalance of power between patients/families and Trusts means this is not an effective form of regulation. The current approach of many Trusts (and NHSR) would seem to be to hope that incident will go unnoticed, the patient/family will be unaware and/or not be able to prove what happened. We suspect that in many cases that approach is successful in avoiding the truth coming out and the patient/family obtaining any form of redress.

12. **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. (Maximum 500 words)

    The idea of ‘safe space’ and/or investigation reports not being shared with a patient/family runs contrary to the duty of candour.