# Key findings from the call for evidence on the statutory duty of candour

28 November 2024 Katie Viggers

In May 2024, Browne Jacobson hosted a Shared Insights session regarding the government's call for evidence on the statutory (organisational) duty of candour. The Department of Health and Social Care has now published its findings in relation to this call for evidence.

Three prominent themes were identified from the survey, namely culture (of the health and care system), inconsistency in understanding and applying the duty and the need for further training.

## Summary of main findings

- 2 in 5 respondents (40%) thought the purpose of the statutory duty of candour is clear and well understood. Some commented that the duty has become a tick-box exercise, with staff and providers going through the motions to fulfil the duty, and not demonstrating compassion, for example through the use of standard templates and wording in letters to patients and/or service users which appear impersonal.
- Over half of respondents (54%) did not think staff working for health and social care providers know of and understand the duty's requirements. Respondents felt that application of the duty is inconsistent and open to (mis)interpretation. This may be due to confusion between organisational and professional duty of candour, variations in staff interpretation of criteria for triggering a notifiable safety incident, and some groups having less knowledge of the duty, such as non-clinical, new or agency staff.
- Less than 1 in 4 respondents said that the duty is correctly complied with when a notifiable safety incident occurs (23%). Some felt staff are reticent about complying with the duty for fear that it admits fault and liability and leaves them open to blame. Others reported instances where staff were empathetic and aimed to follow the process, but senior management did not support them, and they feared not being protected if considered a 'whistleblower'. Some respondents also believed there to be a culture of covering up incidents, falsification of records and dismissal of complaints.
- Respondents were divided in their assessment of provider engagement with 94% of patients or service users disagreeing that providers engage meaningfully and compassionately with those affected after a notifiable safety incident, compared to 27% of health or care professionals.
- Some patients and service users do not understand their rights. Specifically, their rights to access documents and receive an apology or response from a healthcare provider, and what they can do if they feel their case meets the criteria, but communication has been inadequate, or processes not followed.
- Generally, respondents who were patients, service users, family members or caregivers were more critical of the duty and its application, compared to health and/or care professionals and organisations.

## What next?

The government has now launched another public consultation to gather views on regulating NHS managers, including the possibility of introducing a professional duty of candour for NHS managers. This consultation is open until 18 February 2025.

The government says that it will carefully consider both the responses to the manager regulation consultation (the findings will be published as soon as possible following closure of the consultation), and the call for evidence on the statutory duty of candour, as it

continues to develop policy on candour in healthcare. We will keep you informed of any further updates.

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