

Telling patients the truth when something goes wrong

Evaluating the progress of professional regulators in embedding professionals' duty to be candid to patients

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About the Professional Standards Authority

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 voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

To encourage improvement we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation.¹ We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and care workforce.

We are committed to being independent, impartial, fair, accessible and consistent. More information about our work and the approach we take is available at www.professionalstandards.org.uk.

¹ The Professional Standards Authority (2015). [Right-touch regulation – revised](#)

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1. Background

- 1.1 Telling patients openly and honestly that something has gone wrong with their care is an essential part of a healthcare professional's practice. The obligation to do so is known as the professional duty of candour. It can be difficult for professionals to do for a variety of reasons, but they are expected to be candid by the public and regulators. Inquiries and investigations over the years have found evidence that health professionals have failed to tell the truth when a patient has been harmed, whether by withholding or misrepresenting the facts.
- 1.2 This paper explores how UK professional regulators have attempted to encourage healthcare professionals to be open and transparent when something has gone wrong in the care they or someone else have provided. This is known as the professional duty of candour. The paper looks at what progress has been made since 2014 when the regulators published their joint statement on candour encouraging their registrants to be candid; and in enforcing the professional duty of candour through fitness to practise processes.²
- 1.3 Issues of openness, transparency and candour were prominent in 2013 in the aftermath of the publication of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Report).³ Patients and their relatives fought for a long time to find out the truth about their care. These issues are still pertinent now, as evidenced in the Hyponatraemia Inquiry of Northern Ireland, which focused on the deaths of five children. Among its findings, the report found that there was 'repeated lack of honesty and openness with the families' of the children.⁴
- 1.4 In 2014 in response to the Francis inquiry report, the Government published *Hard Truths*.⁵ In that report, the Government stated that it was introducing a statutory duty of candour on all Care Quality Commission (CQC) registered providers in England, making it a requirement for them to be open and honest where there have been failings in care. It was introduced in England in 2014. A duty came into force in Scotland in April 2018. It is currently being consulted on in Wales and has been called for in Northern Ireland in the wake of the Hyponatraemia Inquiry.
- 1.5 *Hard Truths* also made clear that issues of candour were applicable to professionals as well as to organisations. The Government noted that it was working with professional regulators to strengthen references to candour in professional regulation and professional regulators would be working to agree consistent approaches to candour and reporting of errors. In 2013, the Government asked the Professionals Standards Authority to advise and report on regulators' progress in encouraging candour.⁶

² [Joint statement from the Chief Executives of statutory regulators of healthcare professionals](#) (2014).

³ [Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry](#) chaired by Robert Francis QC, (2013).

⁴ [Report of the Inquiry into Hyponatraemia related Deaths](#) p72, chaired by John O'Hara QC, (2018).

⁵ HM Government (2014). [Hard truths: the journey to putting patients first](#).

⁶ Professional Standards Authority (2013), [Can professional regulation do more to encourage professionals to be candid when healthcare or social work goes wrong? Advice to the Secretary of State](#)

- 1.6 The nine regulators we oversee established a working group to develop a consistent approach to candour. They developed a joint statement on the professional duty of candour, which was signed by eight of the regulators. They also committed to review standards where necessary, encourage registrants to reflect on the duty, and other initiatives. In 2014, we commended the regulators on their commitment to developing a common approach.⁷ We did emphasise though that there was more work to be done to fully embed a common approach to candour.
- 1.7 After this, many regulators worked to encourage their registrants to behave candidly through various means like updating standards, developing guidance and altering fitness to practise guidance. Since our report to the Secretary of State on the progress of the regulators, we have commented in responses and performance reviews about the approaches of individual regulators and governments to candour. We now want to look at the progress of the regulators in embedding candour and how candour can be further encouraged in professionals. Another reason for this paper is that, despite the joint statement by regulators, we have subsequently seen little reference being made to the duty of candour in the allegations being brought by any of the regulators, or in the determinations of fitness to practise panels.
- 1.8 This paper is also a chance to revisit conclusions we have previously made in our analysis of barriers to professionals being candid and understand if there are new barriers and whether previously identified barriers remain.⁸
- 1.9 To understand reasons in paragraph 1.7 and delve into detail about the barriers to candour, we created questionnaires and sent them to stakeholders across health and social care, as well as posting a call for information questionnaire on our website, which was open to organisations and individuals to respond to. We then hosted discussion groups with staff from regulators and fitness to practise⁹ panellists, which were facilitated by Annie Sorbie, Lecturer in Medical Law and Ethics at the University of Edinburgh.
- 1.10 This paper is focused on the candour of professionals to those in their care and their families when a mistake has been made. It does not look at whistleblowing, which is when an individual reports workplace concerns about unsafe care or wrongdoing. However, there is an overlap between the two and they are both affected by similar factors, so there may be learning from this paper for whistleblowing.
- 1.11 We recognise though that the workplace culture in which a professional practises can influence professionals' candour towards patients: working in an environment that prizes openness is more conducive to professionals being open and honest

⁷ Professional Standards Authority (2014). [*Progress on strengthening professional regulation's approach to candour and error reporting: Advice to the Secretary of State.*](#) .

⁸ Professional Standards Authority (2013). [*Candour, disclosure and openness Learning from academic research to support advice to the Secretary of State.*](#)

⁹ Fitness to practise is a process in which a regulator will investigate a concern raised by an employer, the public, practitioner or other body about a registrant. In order to protect the public, the regulator may issue sanctions ranging from warning a registrant to erasing them from the register.

with patients. We bring attention to this factor when discussing barriers to candour in chapter 4.

2. Methodology

- 2.1 We first carried out desk research to collect data for the project. The findings of the desk research shaped the questionnaires we sent to different organisations and the priorities we set for the facilitator of the discussion groups. Most of the evidence used in this paper was collected by tailored questionnaires sent to regulators and other organisations across health and social care and a call for evidence on our website asking organisations and individuals to respond, and discussion groups with staff members and fitness to practise panellists of regulators.

Desk research

- 2.2 We reviewed thoroughly the regulators' documents to understand where candour featured in their practices. We also revisited our past findings on candour and the recommendations we made to the Secretary of State. We followed the discussions around candour in contemporary events like the Hyponatraemia Inquiry and the debate around the Health Service Safety Investigations Bill.¹⁰ We analysed reports by authors and organisations beyond regulation on issues relating to candour such as the Royal College of Surgeons review by Sir David Dalton and Professor Norman Williams on proposals to enhance candour.¹¹

Questionnaires

- 2.3 We created questionnaires that were tailored to different types of stakeholder in the health and care sector. These were split into the following types: professional regulator, education provider, legal and professional/representative organisation. For organisations that did not fit into those categories, we sent a less specific questionnaire. We chose a variety of stakeholders across the sector to contact because our previous work on barriers to candour had found that there was a range of factors which affected the candour of professionals. This variety of stakeholders across health and care helped to give non-regulatory perspectives on candour and a chance of situating the extent of regulation's role in influencing candour.
- 2.4 There was overlap in the questions of all the questionnaire types. For example, all questionnaires included the question: 'Do you think there has been a change in professionals' attitudes to candour since 2014? (the regulators' joint statement was published in 2014) If so, how?'. The shortest questionnaire was six questions, whilst the longest questionnaire was 13 questions. We received responses from 30 organisations, in addition to the nine regulators we oversee.
- 2.5 We posted a call for information on our website, which included a shortened questionnaire of six questions that overlapped with many on the bespoke questionnaires described above. This gave an opportunity for organisations we had not contacted to contribute information to this paper. We received responses from 10 organisations.

¹⁰ See our [evidence](#) to the Joint Committee on the Draft Health Service Safety Investigations Bill.

¹¹ Sir David Dalton, and Professor Norman Williams (2014) [Building a culture of candour](#). Royal College of Surgeons.

2.6 The call for information also invited individuals to contribute. They were asked to complete the same questions as organisations in the call for information. We received responses from 11 individuals. Most were health and care practitioners.

Discussion groups

2.7 To better understand issues of candour related to fitness to practise, the Authority hosted discussion groups with people involved with fitness to practise at different regulators. While recognising the limitations of this method, the groups were an opportunity to listen to different perspectives on themes from the questionnaire responses and to explore any notable points that were absent from many questionnaire responses, for example the role of the public in candour. The discussions were facilitated by Annie Sorbie, Lecturer in Medical Law and Ethics at the University of Edinburgh. Annie added a critical eye to the findings, drawing them together and identifying themes, which she then relayed to the Authority.

2.8 There were two discussion groups, which convened on consecutive days. No participant took part in both groups. The groups were organised around the following participant types:

Discussion group one	A discussion between regulatory staff who help with triage, investigation and fitness to practise matters
Discussion group two	A discussion between case examiners, investigation panel members and fitness to practise panel members

2.9 There were six participants in the first group and seven in the second group. All regulators, except one, were represented at one or both of the discussion groups.

2.10 All information provided by discussion group participants has been treated in confidence: participants' contributions will not be attributed individually or to their respective regulators. The conduct of the discussion groups was approved by the University of Edinburgh's Research and Ethics Committee.

3. Understanding and measuring candour

- 3.1 Earlier, this paper outlined candour as a professional being 'open and transparent when something has gone wrong' in care for a person. A more comprehensive definition of candour is the one listed in the joint statement by regulators.

The professional duty of candour

Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress. This means that 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-term effects of what has happened.

Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns.¹²

Figure 1: Joint statement by the regulators on the Professional Duty of Candour

- 3.2 We used the regulators' joint definition of candour in all questionnaires and information sheets to prepare participants for the discussion groups. This will be the longer working definition of what we mean by candour of professionals in this paper. As mentioned earlier, this paper will focus on professionals' candour towards patients and not on professionals' candour to other colleagues, employers and relevant organisations. However, this paper does touch on these topics a few times as they are often intertwined. For instance, it was pointed out by one discussion group participant that when something has gone wrong, it is not just patients who are informed but also other professionals and senior managers. The result of this is that there are inter-professional considerations when a professional is making a candid admission in the event of an error.
- 3.3 Some stakeholders in our 2013 candour work highlighted that 'the words candour or candid...are not widely understood words and/or mean very different things to different people'.¹³ This has been echoed again in this report where one regulator noted that the term candour is a 'difficult one', which it had to debate with its

¹² [Joint statement from the Chief Executives of statutory regulators of healthcare professionals](#) (2014).

¹³ Professional Standards Authority (2013). [Can professional regulation do more to encourage professionals to be candid when healthcare or social work goes wrong? Advice to the Secretary of State](#) p40.

registrants over using implicitly or explicitly in their code. One professional body relayed that some of its members suggested the duty could be better explained using more 'everyday language' than the duty of candour. Additionally, a few respondents noted that professionals have had a duty to be candid for many years, with one organisation suggesting that professionals view the professional duty of candour as a 'repackaging and relabelling' of a normal professional responsibility.

- 3.4 Awareness of the need to be candid amongst professionals is not just shaped by the duty of candour definition on the previous page. One stakeholder noted that 'significantly higher' awareness of candour since 2014 was not just down to the duty of candour but also as a result of high-profile healthcare issues in the media such as the Montgomery case, where informed consent of a patient was the focus.¹⁴ However, the public's awareness of the duty of candour is debatable, with discussion group participants suggesting to us that the public rarely mention the duty of candour.
- 3.5 Awareness of candour has been tempered by confusion over the types of candour. As mentioned in the background to this paper, there are two duties of candour: statutory (or organisational) and professional. The former refers to the organisational duty for healthcare provider organisations to be open and honest with patients and families. A few respondents to the questionnaires noted that there was overlap between the two duties and that this was sometimes confusing, or even frustrating, for professionals. Additionally, a stakeholder observed that the 'conflation' between the two duties of candour can sometimes be counter-productive and not helpful for patients in the event of a notifiable safety incident¹⁵ being triggered where it should not. The stakeholder described that the professional duty of candour is a 'common sense principle' for the relationship between professional and patient where the professional is expected to explain all the steps of treatment to a patient throughout their entire time of care. This could be reaffirmed and strengthened, but not replaced by a 'bureaucratic, Trust-led process'. This example shows that a candid atmosphere should prevail in all circumstances of care and that there are limitations to this being enforced by 'bureaucratic' mechanisms of healthcare providers.
- 3.6 Another stakeholder suggested it could be helpful if the professional duty 'when something goes wrong' threshold could be incorporated as a new level within the

¹⁴ [Montgomery \(Appellant\) v Lanarkshire Health Board](#) (Respondent) [2015]

¹⁵ A notifiable safety incident means: 'any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a healthcare professional— (a) appears to have resulted in— (i.) the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, (ii.) an impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days, (iii.) changes to the structure of the service user's body, (iv.) the service user experiencing prolonged pain or prolonged psychological harm, or (v.) the shortening of the life expectancy of the service user; or (b) requires treatment by a healthcare professional in order to prevent— (i.) the death of the service user, or (ii.) any injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in subparagraph (a).' This definition comes from the CQC's [Regulation 20: Duty of Candour](#).

organisational duty of candour so that health professionals and administrators can work to one streamlined system.

3.7 On comparing the two duties, one organisation concluded that the organisational duty of candour is more useful for professionals as it sets out how serious the harm has to be before the duty of candour process must be initiated. More details can be found in paragraph 5.10.

3.8 It is also of note that the professional duty of candour not only overlaps with the organisational duty of candour, but also with the NHS complaints process where there is a requirement on public bodies to be open and honest when accounting for decisions and actions and the need to explain fully when things have gone wrong and how they can 'put matters right as quickly as possible'.¹⁶ One stakeholder suggested that if the duty of candour complements the public bodies' complaints process, it could reduce reliance on that process and provide 'outcomes that people might otherwise have sought from making a complaint'.

Measuring candour

3.9 Throughout this project an obstacle to fully understanding the effects of regulatory interventions on candour is that it is difficult to measure candour quantitatively. Many stakeholders and regulators observed that difficulty in measurement stems from the qualitative nature of candour, one stakeholder suggested that the duty of candour is 'mainly a qualitative attribute'.

3.10 It was also noted by one regulator that 'care needs to be taken with using fitness to practise as a measure, as effective candour by practitioners might actually reduce the likelihood of patients raising concerns'. Another stakeholder highlighted that regulators are in a better position to measure the absence of candour through fitness to practise allegations than the practice of candour. A few stakeholders observed that measurement of compliance to the duty of candour can be useful but does not ensure that candour is meaningful. One stakeholder organisation noted: 'The problem is, however, that the focus is on 'compliance' rather than professionalism. There is a wish now to 'count' what happens rather than supporting professionals with dealing with difficult situations.' One professional organisation pointed out that the duty of candour has 'less to do with a culture of a compliance and more to do with a culture of responsibility'. The potential negative aspects of counting candour were also observed by another organisation that was concerned that the creation of a system to measure compliance could create 'perverse incentives and undesirable outcomes'.

3.11 Some stakeholders suggested that it was possible to measure candour. This could be aided by greater consistency about how the issue is approached across the health and care sector. If a system of measurement were to be instituted, stakeholders suggest the following as sources of data for measurement (this is not an exhaustive list):

- Feedback from patients and families on candid behaviour of professionals
- Fitness to practise (FtP) data from professional regulators

¹⁶ Parliamentary and Health Service Ombudsman (2009). [Principles of Good Complaint Handling](#) p8.

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- Healthcare providers
 - Peer review
 - Annual staff survey
 - System regulators
 - Complaints bodies.

4. Factors that encourage and discourage candour

- 4.1 In this chapter we will outline the main factors that discourage and encourage candour in professionals. Many of the factors we discuss below we identified previously in our advice to the Secretary of State in 2013.¹⁷ Although it is a limited sample, it is striking that the word ‘fear’ was mentioned when discussing barriers to being candid by 37 of the 60 organisations/individuals that responded to the questionnaire and call for information. This could be fear of litigation, fear of the regulator striking a professional off their register, or fear of public and media perceptions and the ensuing impact on a professional’s livelihood.
- 4.2 This chapter is not a comprehensive list of all the factors encouraging and discouraging candour. For the factors which discourage candour we have sometimes picked out ideas suggested by questionnaire responses to remedy the issue and examples of how organisations are attempting to change that discouraging factor. We go into more detail in the next chapter over how regulators have worked to overcome those barriers.

Workplace

- 4.3 There was a widespread view amongst questionnaire respondents that organisations which had a blame culture, or a culture of defensiveness, were not environments in which the professional duty of candour could thrive. A few identified this as the key factor for influencing candour.
- 4.4 One complaints organisation commented that if an organisation’s culture is defensive then staff can be fearful about making admissions as they may be ‘criticised or judged by colleagues and employers’. The organisation also noted that it had seen letters where Boards had downplayed the significance of comments professionals had made to patients suggesting that the comments were inaccurate or needed to be seen in context. The organisation noted that ‘this approach is not likely to encourage the professionals involved to continue to be open with patients’.
- 4.5 A professional body similarly noted that professionals may fear being ‘isolated from colleagues’ if they were candid. Professionals may find their careers affected as a result of being candid, as one education organisation put it, there is a fear that ‘if you make a fuss you won’t end up working in that team’. The same organisation also pointed out that there could be a detrimental impact on a professional’s career if they raised a concern that may ‘annoy’ senior colleagues and similarly for trainee progression due to any investigations that may result from raising concerns. Another organisation observed that trainees do not ‘always feel empowered to apologise individually due to their perception of their status’ within their teams.

¹⁷ [Candour, disclosure and openness Learning from academic research to support advice to the Secretary of State](#), Professional Standards Authority, 2013.

- 4.6 However, healthcare provider organisations can also encourage candour in professionals. A stakeholder noted that a culture of candour can exist in organisations where there is good leadership which understands its staff. This means staff can be supported in moving towards an open culture. Similarly, some discussion group participants felt that candour could be encouraged by positive relationships between different types of regulated professionals who worked together, as well as regulated and unregulated staff.
- 4.7 A professional's level of autonomy, suggested one organisation, could influence how confident they feel about being candid with patients. The organisation observed that 'autonomous clinician' roles such as general practitioners 'felt more at ease' than other professionals when being candid due to their 'greater sense of accountability'.
- 4.8 We also saw in questionnaire responses that professionals may lack belief in candour having any meaningful or constructive outcomes in order to prevent a recurrence.

The importance of timeliness

- 4.9 A professional's workload and the associated stresses of a heavy workload can mean professionals are limited in the time they have to spend with patients when a problem has occurred. A number of organisations and discussion group participants noted the negative effects of workforce shortages on workloads and candour by extension. One professional body noted that professionals delivering care outside of normal working hours, sometimes under 'intolerable pressure and workload' can be compromised in their ability to adequately deliver high quality care, of which candour is a component.
- 4.10 One stakeholder noted that the authenticity of an apology can be affected by the time between an incident and a claim. A professional's recollection of the events that happened can be limited due to the time that has passed, the stakeholder suggested. In patients' minds, this lack of recollection can call into question the authenticity of an apology. One means to reduce the chance of this occurring is good record-keeping. Additionally, a firm of solicitors highlighted that when things go wrong patients often feel 'out of the loop' and with little support from a hospital or Trust whilst it conducts an investigation, which can often be 'lengthy'.
- 4.11 It was noted in discussion groups that a professional's mistake might not come to light immediately. In some circumstances a professional might only realise they have made a mistake at a later date, or even when they are contacted by their regulator. It was suggested that one impact of the passage of time was that it could be harder for a professional to acknowledge that they had not done their best on a particular day.
- 4.12 Discussion group participants also discussed how windows of opportunity for candour could be created, or indeed lost, in the regulatory process. This has more relation to candour of professionals to regulators than to patients but is an interesting observation nonetheless. The group facilitator, Annie Sorbie, later termed this a 'regulatory space' for candour. An example of lost regulatory space is if a robust local investigation of a professional's conduct had not taken place prior to referral to the regulator. Regulatory space for candour might be created

where a regulator's legislative framework has the flexibility to allow and encourage a candid two-way exchange of information at an early stage before formal aspects of the process are invoked. Communication with professionals is seen as key in order to encourage engagement with the fitness to practise process and there needs to be support structures and resources available to address training needs resulting from candour failings. This may be of particular interest to regulators in relation to consensual disposal¹⁸ or continuing fitness to practise as potential tools to create a 'regulatory space'.

Education and training

- 4.13 A number of questionnaire respondents and discussion group participants considered education and training to be key to encouraging candour. Education and training bodies can help trainees understand issues of candour and the implications of being (and not being) candid.
- 4.14 The cornerstone of candour is the communication between a professional and a patient. It was noted by a few stakeholders that education and training bodies can show trainees how to have candid conversations with patients when things have gone wrong. It was observed by organisations that some professionals lacked communication skills to apologise effectively and that others lacked confidence to communicate candidly with patients. A professional body highlighted the importance of training in communication skills in order to support professionals in having open and difficult conversations with patients. It also noted that training would help dispel fears of the legal implications of apologising. The body considered that it would be useful for both professional and system regulators to deliver training in those communication skills. The body referred to the 'useful' practical workshops of the General Medical Council (GMC) on its guidance as a model for this type of training. We also note from other literature and the discussion groups that communication needs to be tailored to patients. They are not one homogenous bloc and will want information communicated in different ways depending on their preference.¹⁹
- 4.15 It was noted by one education organisation that interprofessional education helps to prepare professionals to deliver the professional duty of candour in a multidisciplinary context. It noted that regulators have an important role to play in promoting and enforcing the delivery of interprofessional education in professional courses.
- 4.16 There are limits though to how much education and training can influence professionals to be candid when they get into the workplace. One education stakeholder, referring to Miller's Pyramid (see below), informed us that it had 'little doubt' that medical trainees know ('knows' and 'knows how') their duty to be candid and can demonstrate competence to adhere to it ('shows'). However, the

¹⁸ Consensual disposal is a process used by some of the regulators in cases where there is agreement on the facts of the case and proposed sanctions, and where there may be no public interest or need for a hearing.

¹⁹ Sir David Dalton and Professor Norman Williams (2014). [Building a culture of candour](#), Royal College of Surgeons, p10.

organisation considered that when trying to comply in practice with that duty ('does'), medical trainees were subject to other pressures such as blame culture.

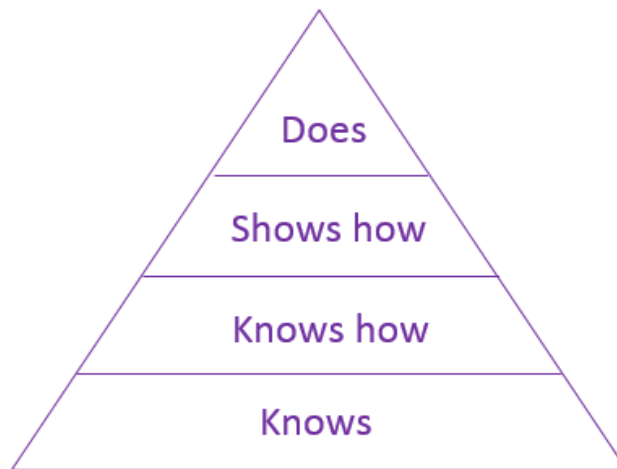


Figure 2: Miller's Pyramid, a way of ranking clinical competence both in educational settings and in the workplace

Fear of the regulator and litigation

- 4.17 The twin prospect of regulatory and criminal or civil prosecution proceedings may discourage professionals from being candid. Some stakeholders considered that professionals may worry that regulators may not be fair to professionals who have been candid and that the regulator may be perceived to be punitive or looking to apportion blame.
- 4.18 The case of Dr Hadiza Bawa-Garba was frequently mentioned in questionnaire responses; a third of the questionnaire responses drew attention to the case.²⁰ Stakeholders pointed to the Bawa-Garba case as an example of an individual being held responsible by a regulator for organisation-wide problems and that admission of errors may result in criminal proceedings. A number of stakeholders and discussion group participants commented that this case negatively impacted trainees and set back work to promote professionals' reflections on errors. High profile cases, and the negative media which go with them, was also cited as a barrier to candour for professionals.
- 4.19 Professionals' fear of civil or criminal prosecution was often discussed in questionnaires. Many mentioned that there is fear amongst professionals that apologising to a patient would lead to negligence claims. There have been attempts to dispel the continuing perception that an apology is an admission of liability, for example NHS Resolution's *Saying Sorry* leaflet²¹ and the General Dental Council's (GDC) guidance on candour.²² One educational body suggested

²⁰ Bawa-Garba is a doctor convicted of gross negligent manslaughter. She was suspended by the Medical Practitioners Tribunal Service. The GMC appealed the decision to suspend, which resulted in Bawa-Garba being struck off after the GMC. The GMC's decision was successfully appealed by Bawa-Garba. More information can be found in this article: [Bawa-Garba: timeline of a case that has rocked medicine](#), Pulse, 2018

²¹NHS Resolution (2017). [Saying Sorry](#)

²² General Dental Council. *Being open and honest with patients when something goes wrong*.

that regulators have a role in ‘destigmatisation of those that disclose failings’. A defence body told us that it made sure that its members were aware that ‘problems are more likely to arise if there is a lack of candour, and less likely if there is openness and honesty with patients’.

- 4.20 Behaving candidly can be a means to reducing the chance of litigation. For example, the University of Michigan Health System has pioneered a malpractice scheme based on early disclosure of errors to the patient, and found that both the litigation costs and the number of claims decreased as a result.²³ A law firm suggested that compliance with the duty of candour ‘would help to resolve those claims which do have merit at a much earlier stage and without the need for prolonged litigation and inflated legal costs’. However, one representative organisation expressed concern about law firms that specialised in ‘no-win no-fee’ approaches lengthening cases against professionals who have tried to do the right thing.
- 4.21 Recent legislation to decriminalise dispensing errors (Pharmacy (Preparation and Dispensing Errors – Registered Pharmacies) Order 2018)²⁴ was heralded in a few questionnaire responses as a step towards encouraging candour in pharmacy professionals. One organisation noted that prior to the Pharmacy Order, pharmacists were ‘reluctant’ to report errors as a dispensing error could be treated as a criminal offence even if there was no ‘malicious intent’. It further noted that the removal of the threat of legal prosecution could lead to ‘stronger and more positive attitudes to candour’ by pharmacists. However, this change in legislation only applied to community pharmacists. It did not apply to pharmacists working in non-community settings such as hospitals.²⁵

Professional regulators

- 4.22 Many respondents to the questionnaires observed that regulators have a role in encouraging candour, describing the role as ‘significant’, ‘vital’ and ‘important’ among other phrases. However, some respondents did not think regulators were well-suited or even had a role to encourage candour. One professional body noted that a regulator should have a minimal direct role informing registrants of the existence of guidance on candour and how it interprets it. It should have no other direct role, emphasising the role of professionals and support organisations. It further noted that it is a ‘harrowing enough experience to find out something had gone wrong and discuss this with a patient, there does not need to be an additional regulatory layer to that process in all situations’.
- 4.23 In all questionnaires, we asked: ‘What role do professional regulators have in encouraging candour among their registrants?’ The main expectations of what the regulators should be doing are:
- Set standards for professionals to uphold

²³ Professional Standards Authority (2013). [Candour, disclosure and openness Learning from academic research to support advice to the Secretary of State](#) pp9-10.

²⁴ [Pharmacy \(Preparation and Dispensing Errors – Registered Pharmacies\) Order](#), 2018

²⁵ A government [consultation](#) on extending decriminalisation to other pharmacy professionals closed in September 2018. It is important to note that questionnaire responses were received in late May of 2018.

- Ensuring professionals are aware of the duty of candour
 - Creating an environment in which professionals can be honest
 - Providing clear guidance to professionals, which can be aided by examples
 - Ensure training providers are making sure trainees are aware of their duty to be candid
 - Work with other healthcare organisations to ensure professionals are being supported to be candid
 - Encourage candour through revalidation
 - Taking action when a professional has not been candid
 - Be part of a no blame culture and be clear on how they will act if a professional is candid.²⁶
- 4.24 These expectations show that professional regulators might have a diverse role in encouraging candour. A recurring theme in questionnaires and discussion groups is that there are limitations to how much regulation can influence the candour of professionals. Regulators are just one part of the healthcare system and they need to forge strategic relationships with other parts of the system such as employers and professional bodies to support a culture of candour.
- 4.25 On fitness to practise, it was noted by an educational organisation that there is a 'perception that the focus is solely on the individual's behaviour and not necessarily taking into account systems issues/failures taking into account the published work on failures in systems'. It went on to suggest that 'in general any untoward incident is because of 80 per cent latent failures built into the system and 20 per cent active failures, action/omission by individuals'. Discussion group participants noted that regulators needed to strike the right balance when dealing with candour in fitness to practise cases. For example, if a professional has been candid about their mistakes, and this is treated as a mitigating factor, then this might encourage candour in other professionals. However, the weight attached to such mitigation will depend on the underlying facts of each case.
- 4.26 A prominent theme of stakeholder responses was that regulators should be fair and not punitive. Many respondents and discussion group participants considered the regulatory sector and the wider health and care sector to be moving away from the 'blame culture'. Many pointed out though that the move away from blame culture had been hampered somewhat by the Bawa-Garba case. Some discussion participants had concerns that an overly adversarial and punitive approach in regulatory proceedings could have the perverse effect of discouraging professionals from being open about their mistakes. Overall, there was widespread support for positive steps to encourage candour, for example through education, and promoting 'positive' candour at a local level. On the other hand, some participants also discussed the role of fitness to practise proceedings in

²⁶ One stakeholder noted that regulators, as well as their registrants, should be candid. This was also a topic of discussion in one of the discussion groups, where participants felt it was important for regulators to be candid about their own failings.

sending out a clear message to professionals and the public about the importance of being candid. Together this highlighted the balance that would need to be struck in regulatory proceedings.

- 4.27 One educational organisation responded to the questionnaire suggesting that regulators should be ‘transparent, supportive and consistent in their approach to dealing with trainees and registrants who have acted candidly’. That organisation further noted that actions taken against registrants must be proportionate to the circumstances.
- 4.28 A few organisations noted there had been a positive move forwards in candour of professionals but ascribed the success of that progress mainly to non-regulatory interventions. For example, the Scottish Patient Safety Programme and ‘Patient Stories’ were praised by some stakeholders for their influence on professionals. The former helped highlight the importance of learning, whilst the latter have been described as a ‘powerful engagement tool’ and have helped contextualise for professionals the positive effects of candour on patient safety. One questionnaire respondent noted that health and care staff feel more empowered to be open and honest but attributed this mainly to the statutory duty of candour.
- 4.29 Finally, regulation may not affect the candour of many professionals as they may be candid anyway or seek advice on candour from other organisations. Many respondents cited non-regulatory sources of advice for professionals on candour. One stakeholder noted that even before the regulators had guidance on candour it had been the organisation’s practice, for over 50 years, to advise professionals who seek its assistance when something has gone wrong to tell patients and to apologise. Professionals who seek its assistance follow this advice, principally because it is the right thing to do and have done so long before it featured specifically in regulators’ guidance. Another respondent told us some of its members questioned whether the 2014 changes have had any discernible and practical impact to date, it gave one example below:

‘We have systems in place for this, but I am not sure DoC [duty of candour] changed much for those providers who were already encouraging an open and transparent culture of reporting and investigation of incidents. So we are very positive and supportive about the DoC principle, but felt that we were taking that approach already so it hasn’t significantly changed how we work.’

Are there limitations to candour?

- 4.30 One stakeholder organisation responded to the questionnaire suggesting that there are ‘limitations’ to candour and that healthcare providers need to ‘respect what patients may not want to know’. The organisation suggested that ‘codes of practices for promoting candour need to be aware of the boundaries’.
- 4.31 One individual respondent to the call for information suggested that currently there are ‘overreactions’ and discussed the need for proportion when being candid through their example scenario:

‘my colleague was involved in an infusion mistake of electrolytes, the patient was managed appropriately and discharged but because some of the

mistakes didn't come to light until after discharge, some are proposing a meeting with the patient. I think in this case, a simple phone call constructed well, handled professionally is sufficient unless the patient wishes further information'

- 4.32 Some of the factors discussed in this section were also explored in one of the discussion groups. Some participants commented that there may need to be 'subtlety in explanations of risk' and that there were 'shades of grey'. It was suggested that because discussions around candour could be rather 'nebulous' case studies might be helpful to guide professionals when faced with a dilemma of candour.
- 4.33 On the issue of withholding information from patients when something has gone wrong, the GMC and the Nursing and Midwifery Council's (NMC) joint guidance on candour notes that patients will normally want to know more about when something has gone wrong but a professional should give them the option not to be given every detail. If a patient does not want more information a professional should explore their reasons for their decision and explain the consequences for the patient. A professional should then respect the patient's wishes, recording this and making it clear to the patient that they can change their mind.²⁷ The GDC's guidance for its registrants makes similar remarks.²⁸
- 4.34 It is worth noting the Dalton/Williams Review of candour on this issue. The review authors suggest that any decision to depart from normal expectations of disclosure 'needs to be considered thoroughly and based on clear evidence'. It goes further to caution that professionals and organisations should be 'sceptical' of paternalistic arguments and that such arguments should be 'used sparingly rather than becoming a default attitude'.²⁹

Indemnity and defence bodies

- 4.35 Questionnaire responses mentioned that professionals may be fearful about how candour can affect their insurance indemnity arrangements, for example by increasing premiums or even nullifying insurance. The General Osteopathic Council (GOsC) noted that some respondents to its consultation on revised Osteopathic Practice Standards in 2017 thought that a proposed standard on duty of candour was not clear and wanted more guidance about the relationship between candour and insurance.³⁰ Participants in our discussion groups noted that there was concern amongst professionals that if they apologised they might 'lose' their insurance cover, it was acknowledged that although this was not true the 'myth' persisted. A defence organisation told us that indemnity arrangements 'should not and do not' have an effect on the ability of professionals in its remit to be honest to patients, and that it made clear to its members nothing should prevent them from telling patients when things go wrong or apologising. The defence body further noted that defence bodies have an important role in

²⁷ GMC and NMC (2015). [Openness and honesty when things go wrong: the professional duty of candour](#) p3.

²⁸ GDC (2016). *Being open and honest with patients when something goes wrong*.

²⁹ Sir David Dalton and Professor Norman Williams (2014). [Building a culture of candour](#), Royal College of Surgeons, p32.

³⁰ It was a small proportion of respondents that did not consider the guidance was clear: 9 out of 122.

encouraging candour as they are often the first place a professional may seek advice.

- 4.36 This relationship – between candour and professionals receiving representation and advice (from defence organisations or lawyer) during fitness to practise proceedings – was also considered by some participants in the discussion groups. An observation was made that some professions – particularly those that were lower paid – were less likely to have representation before and at hearings. As a result, they may not have the benefit of the type of advice encouraging candour at an early stage, as outlined above. Fitness to practise proceedings can provide an opportunity for professionals to learn from their experiences and improve their conduct going forward. However, there was a suggestion by some participants that where professionals were not well supported during hearings, or indeed did not engage with fitness to practise proceedings at all, they may find it hard to explain the context of their failings and/or to express how they had taken steps to remediate these mistakes.
- 4.37 Conversely, it was also noted in one discussion group that represented professionals may be ‘cajoled’ into taking courses, and to show insight and remediation. However, it was suggested that some professions, for example outside of medicine, do not have the support structure and resources for re-education.

Professionals’ expectations of making an error

- 4.38 For a professional, coming to terms with the fact that they are likely to make a mistake in their career could encourage them to be candid when something has gone wrong. It was suggested by one regulator that as healthcare professionals tend to be ‘high-achievers’ they may be inadequately prepared to deal with error or failure. In healthcare, there is always a possibility that an intervention can go wrong or even high achievers may make mistakes.
- 4.39 Another report on candour observed: ‘clinical care is inherently risky, and while organisations and individuals must do all they can to minimise risks, it will never be possible to eliminate them fully. Candour will therefore always be necessary...’³¹ Discussion group participants and a few questionnaire respondents also noted that it is not realistic to expect humans to never make errors, with one participant noting that ‘no professional will be error-free their entire career’. Therefore, enabling professionals and trainees to understand there is a chance they will make errors in their careers might encourage candour.

³¹ Sir David Dalton and Professor Norman Williams (2014). [Building a culture of candour](#) Royal college of Surgeons, p10.

5. How have regulators embedded candour?

- 5.1 In this section we explore how regulators have attempted to embed candour. Some respondents commented that there were nuances and differences between regulators in approaches, one stakeholder commented on the variation between regulators in approaches to fitness to practise. Another stakeholder observed that there is a 'perceived inequity' in the way different professions are treated by regulators when there is a clinical error and a belief that doctors 'escape blame and punishment' compared to other colleagues. However, one organisation responding to the questionnaire did welcome the 'cross-regulator' approach to candour, noting that there is 'strength in consistency of language and approach'.

Standards, codes and accompanying guidance

- 5.2 A key means for a regulator to show that candour is expected of a registrant is by having it as a standard of practice. All the regulators have standards relating to candour. The main standards of each regulator relating to candour can be found in Appendix A of this paper.
- 5.3 Beyond the main standards, there are also other standards in a regulator's code or standards which reinforce candour. For example, the General Chiropractic Council (GCC) has the main standard of:

B7: Fulfil the duty of candour by being open and honest with every patient. You must inform the patient if something goes wrong with their care which causes, or has the potential to cause, harm or distress. You must offer an apology, suitable remedy or support along with an explanation as to what has happened.

Figure 2: GCC standard of duty of candour

- 5.4 The GCC also has the following standards elsewhere in its code, which reinforce the need for registrants to be candid:

B: Act with honesty and integrity and maintain the highest standards of professional and personal conduct.

F1: Explore care options, likely outcomes, risks and benefits with patients, encouraging them to ask questions. You must answer fully and honestly, bearing in mind patients are unlikely to possess clinical knowledge.

A3: Take appropriate action if you have concerns about the safety of a patient.³²

Figure 3: Various GCC standards relating to candour

- 5.5 In addition to the standards and codes for professionals, two regulators have standards for businesses. The General Optical Council (GOC) recently consulted on new draft standards for businesses which included explicit references to candour in its standard for business practices to be open and transparent.³³ The General Pharmaceutical Council (GPhC), which regulates premises, has a

³² General Chiropractic Council (2016). [Guidance on candour](#)

³³ General Optical Council (2018). [Standards for Optical Businesses](#)

standard of 'There is a culture of openness, honesty and learning' as well as other standards around raising concerns, learning from mistakes and staff empowerment to provide feedback and raise concerns.³⁴

- 5.6 A few stakeholders have noted that the regulators have had some success in highlighting to a wide audience of professionals and other stakeholders the worthiness of apologising and actions to avoid the reoccurrence of something going wrong. There were positive comments also for how regulators communicated what candour means in practice for professionals.
- 5.7 One stakeholder noted that the regulators' updating of standards, guidance and codes raised the profile of candour, and that there was a focus on registrants using standards and codes to support practice, rather than being used by employers as a 'stick'. They commented that this helps promote good practice.
- 5.8 The GOC found that 86 per cent of registrants it surveyed were confident in their ability to meet the revised standards of 2016 (when candour related standards were added) and only 2 per cent were not aware of the revision of standards. When looking at how registrants' practice has changed since the new standards were introduced, 16 per cent said they focus more on candour and communication with patients. However, when discussion group and interview participants in the same project were asked if there were any standards that were unclear or unhelpful, they cited the duty of candour standard 'saying that it was confusing that if a mistake is made there should be an apology to the patient but no admission of liability'.³⁵
- 5.9 The NMC noted that the introduction of an explicit candour standard to its Code has 'ensured that there is a growing awareness of the need for candour as a core element of professional practice'. However, one organisation suggested that the NMC Code and joint guidance with the GMC lack clarity and specificity, which then make it harder for professionals to know when they need to comply, and therefore less able to do so and can even set up a tension between the managers and clinicians. It made reference to an example of one of its members:
- 'In my own organisation, duty of candour is enforced and managers are questioned if it is not acted upon when a patient safety issue occurs. This can be difficult for clinicians in end of life cases where care has not been as good as it should have been but has not caused or accelerated the patient's death, but being honest with family can cause further distress. There is certainly a challenge in managing these few cases.'*
- 5.10 The organisation pointed towards the organisational duty of candour as being better than the professional duty because it 'sets out how serious the harm has to be before the duty of candour process must be initiated.' The organisation also went on to say: 'In the joint guidance there is even a discussion about whether near-misses should be reported to patients and families, without much of a steer about when this should take place. However, there is at least a recognition in that section that reporting that things have gone wrong can be distressing for patients and their families and allows the health professionals to take this into account'. We

³⁴ General Pharmaceutical Council (2018). [Standards for registered pharmacies](#)

³⁵ General Optical Council (2016). *Registrant Survey 2016 Final Report*. Entventure Research.

are conscious from other feedback we received that being overly prescriptive in guidance and codes can have negative consequences. Case studies may have a role to play in helping professionals better understand how guidance and codes can be applied.

- 5.11 The GCC noted that it has ensured that its registrants are ‘fully aware’ of their duty of candour through publishing and promotion of guidance and drawing attention to the joint statement of candour by regulators. It also noted that in 2015 and 2016, it administered surveys to education providers and chiropractic students on attitudes to professionalism, although the number of individuals who responded was low, the surveys showed that the undergraduate students who completed the survey were aware of the requirements of the duty of candour even though the word ‘candour’ was not used. Survey participants were given a list of hypothetical scenarios that displayed a lack of professionalism and were asked to indicate whether they believed the situation to be ‘wrong.’ The total number of individuals who completed the survey in both years was very low, however, all student participants agreed that the hypothetical situation that fell under the duty of candour (‘A fellow student asks you to cover up a mistake in the clinical care of the patient’) was wrong with 89 per cent indicating that they believed it was ‘seriously wrong.’
- 5.12 The Health and Care Professions Council (HCPC) observed that it has seen a ‘positive shift’ in registrants’ attitudes to candour since its standards were changed. Feedback indicates that its registrants are aware of their obligations in this area and feel supported by the HCPC when raising concerns. The HCPC also regularly receives requests for written confirmation of its expectations from registrants to support them in this regard. It also noted that it continues to highlight the requirements to be candid in its stakeholder meetings and has received positive feedback.
- 5.13 Five regulators (GCC, GDC, GMC, GOC and NMC) have produced candour specific guidance documents for registrants to supplement standards and codes. The GDC noted that guidance not only sets out requirements but can promote an idea to professionals. When publishing its guidance on candour the GOC considered that guidance can assist registrants in applying a regulatory standard and extra confidence in applying the standard.³⁶ The GPhC has guidance – *In practice: Guidance on raising concerns* – around applying its standard relating to candour and raising concerns. The guidance states that the duty of candour is at the ‘heart’ of the standard.³⁷
- 5.14 The GMC and NMC developed joint guidance on candour for doctors, midwives and nurses.³⁸ The guidance sets out the standards expected of the three professions. The guidance has received national coverage, including in the traditional media, press statements and tweets from the Health Secretary, King’s Fund and others. In addition, the NMC produced a number of case studies to help its registrants with the duty of candour, what it means for their practice and how to

³⁶ General Optical Council (2017). [GOC publishes guidance on professional duty of candour](#),

³⁷ General Pharmaceutical Council (2017). [In practice: Guidance on raising concerns](#)

³⁸ General Medical Council and Nursing and Midwifery Council (2015). [Openness and honesty when things go wrong: the professional duty of candour](#)

meet it in a range of scenarios. These case studies were developed with the help of practising midwives and nurses.³⁹

- 5.15 The GOsC's recent consultation on Osteopathic Practice Standards found that a large percentage of respondents felt the candour guidance was clear and easy to use. They were asked the following question: '10. Is the updated standard D3⁴⁰ and its guidance in relation to the duty of candour sufficiently clear and easy to use?' The GOsC received 122 responses to this question of which 113 considered the guidance was clear and accessible and nine did not. Those that said 'no' wanted more guidance about the relationship between an apology and their professional indemnity insurance.

Education and training (prior to full registration with a regulator)

- 5.16 As mentioned in the last section, education and training is a key way to encourage candour among health and care professionals. All the regulators have made steps to embed candour in education and training. Four of the regulators (GCC, GDC, GMC and NMC) explicitly mention candour in their standards for organisations providing education and training to trainees. These can be found in Appendix B of this paper. The NMC found that there was strong support from stakeholders to embedding the professional duty of candour in its new Education Standards.
- 5.17 The HCPC revised its standards for conduct, performance and ethics in 2016, this included a provision for the duty of candour. The HCPC has required education providers to confirm, via annual monitoring,⁴¹ that they have embedded the revised professional standards relating to candour. Additionally, the HCPC has revised its standards for education providers to explicitly require education providers to evidence how their learning outcomes ensure learners understand the implications of the conduct, performance and ethics standards like the requirement to be candid.
- 5.18 The GPhC and the Pharmaceutical Society of Northern Ireland (PSNI) noted that in their capacity to quality assure⁴² the education and training of MPharm pharmacists, they require universities providing the training to teach the standards of candour expected of pharmacy professionals. The GPhC also noted that pharmacy technician providers going through the accreditation and recognition process must provide evidence of how candour is embedded in their training.
- 5.19 The GMC refers to the duty of candour in its Generic Professional Capabilities Framework under requirements for professional values and behaviours. The Framework seeks to embed common generic outcomes and content across all postgraduate medical curricula, which will need to be embedded in every post-graduate curriculum by 2020.⁴³ An educational organisation noted that this is a 'very positive step as it gives a level of clarity for trainees and trainers'.

³⁹ Nursing and Midwifery Council (2015). [The professional duty of candour: Nursing case studies](#)

⁴⁰ Standard D3 states: 'You must be open and honest with patients, fulfilling your duty of candour.'

⁴¹ Annual monitoring is a process where the HCPC considers whether a programme continues to meet education standards and that individuals who successfully complete the programme are able to meet the relevant proficiency standards.

⁴² The PSNI quality assures MPharm students through a memorandum of understanding with the GPhC.

⁴³ General Medical Council (2017). [Generic professional capabilities framework](#)

- 5.20 The GOC stated that as part of its ongoing Education Strategic Review it is embedding more professionalism and professional skills training into undergraduate education, meaning its registrants have a good knowledge of the duty of candour early in their careers.
- 5.21 Other regulators told us about how they raised awareness of issues of candour with students and trainees. The HCPC has updated its guidance to students on conduct and ethics to reflect the duty of candour. The PSNI meets with MPharm students every year to discuss its code, and the importance of the duty of candour is discussed. The PSNI also told us that pre-registration trainees are required to attend an induction day at the beginning of each registration year, in which emphasis is placed on principles (such as the duty of candour) of the PSNI Code and the obligations of professionals and trainees to comply. Pre-registration tutors assess the performance of trainees against the principles of the Code quarterly.
- 5.22 Additionally, a stakeholder informed us that the GMC delivers compulsory professionalism sessions in Northern Ireland to foundation year two trainees, GP trainees and new appointments to specialty training in Northern Ireland. The sessions are evaluated to measure the trainee perception and understanding of professionalism. The importance of being open and honest and the duty to report concerns is emphasised.
- 5.23 The GMC's compulsory professionalism sessions in Northern Ireland were commended by an organisation. It further noted that trainees 'on the whole are very open and honest and readily give feedback' and that education and training bodies have been successful in encouraging those in training to be candid through e-portfolios where trainees reflect on mistakes and discuss how to communicate this to patients.
- 5.24 In the context of education, a discussion group participant suggested that students' soft skills, such as candour, may be seen by universities as less of a priority for students than their technical skills. They suggested this could send out a message to students about what was 'important'. They further noted that in order to embed candour this needed to be done at an early stage – and not just at the point that a professional was dealing with a mistake.

Continuing fitness to practise

- 5.25 The NMC noted that revalidation has a role in raising awareness of candour to registrants and enabling them to reflect on the role of candour in their practice. The GOC requires optometrists, dispensing opticians, contact lens opticians and therapeutic prescribers to fulfil an element of competence in candour for continuing education and training (CET).⁴⁴ The duty of candour is highlighted in the GMC's updated revalidation guidance in the context of doctors participating in significant event reviews.⁴⁵ Additionally, the duty of candour is referred to in the GMC's information-sharing principles for revalidation.⁴⁶ One professional body stakeholder cautioned that although it is possible for the duty of candour to be included in the appraisal process of a professional and given 'a weight' in the

⁴⁴ General Optical Council (2015). [What are the CET requirements?](#)

⁴⁵ General Medical Council (2018). [Guidance on supporting information for appraisal and revalidation](#)

⁴⁶ General Medical Council. [Information sharing principles](#)

revalidation process of medical professionals, it ‘needs to be done in a way that does not discriminate against those practising in higher risk environment’.

Fitness to practise

- 5.26 A number of regulators feature candour in their fitness to practise documents. The GDC, GOC and GPhC⁴⁷ have sections explicitly discussing candour and focusing on it in their respective fitness to practise indicative sanctions guidance (ISG). The NMC’s online fitness to practise library has a section about candour.⁴⁸ Sanctions guidance for the Medical Practitioners Tribunal Service (MPTS) and GMC refers to the GMC and NMC’s joint guidance and has a section on expressions of regret and apologies.⁴⁹ The HCPC’s indicative sanctions guidance mentions that ‘Panels should regard registrants’ candid explanations, expressions of empathy and apologies as positive steps’.⁵⁰ The HCPC and PSNI both consulted recently on revising their indicative sanctions guidance, both included sections focusing on issues relating to professionals’ duty of candour.^{51,52} The GOsC also consulted on doing the same in 2017.⁵³
- 5.27 These documents show that, broadly speaking, there can be positive and negative circumstances in which candour can manifest in fitness to practise. For example, this is exhibited in the GPhC’s guidance which guides the committees to view registrants’ apologies and candour as ‘positive steps’ whilst committees are warned to take seriously (and consider sanctions at the upper end of the scale) for the deliberate avoidance of candour.⁵⁴
- 5.28 The NMC noted that it introduced an allegations coding framework in 2017 which specifically includes codes related to candour. These specific allegations can be found in the annexe of the Authority’s report on categorisation, which lists the allegation frameworks of all the regulators.⁵⁵ We noted in the main report of the categorisation project that two regulators had allegations that used the word ‘candour’ (GOsC and NMC). We noted though that it is possible for regulators to record fitness to practise issues of candour, without specifically mentioning ‘candour’, through other categories they may be using. For example, the GMC’s ‘Show respect for patients’ category (displayed on the next page) covers issues which could be related to candour.⁵⁶

⁴⁷ In addition to the GPhC’s [Fitness to practise hearings and sanctions guidance](#), the GPhC’s [Investigations and threshold criteria guidance](#) also reiterates the importance of ‘acting with openness and honesty’.

⁴⁸ Nursing and Midwifery Council. [Has the concern been remedied?](#)

⁴⁹ Medical Practitioners Tribunal Service. [Sanctions guidance for members of medical practitioners tribunals and for the General Medical Council’s decision makers](#)

⁵⁰ Health and Care Professions Council. [Indicative Sanctions Policy](#)

⁵¹ Health and Care Professions Council. [Consultation on the revised Indicative Sanctions Policy](#)

⁵² Pharmaceutical Society of Northern Ireland (2018). [Indicative Sanctions Guidance: Draft](#)

⁵³ General Osteopathic Council (2017). [Draft Hearings and Sanctions Guidance consultation document](#)

⁵⁴ General Pharmaceutical Council (2017). [Good decision making: Fitness to practise hearings and sanctions guidance](#)

⁵⁵ Professional Standards Authority (2017). [Categorisation of fitness to practise data annexe.](#)

⁵⁶ Professional Standards Authority (2017). [Categorisation of fitness to practise data](#)

Maintaining Trust	Show respect for patients	Fail to explain error/issue
		Fail to offer apology
		Fail to rectify harm
		Improper relationship with patient
		Inappropriate expression of beliefs

Figure 4: GMC sub-categories of 'Show respect for patients'

- 5.29 Many discussion group participants noted that lack of candour was an issue that frequently arose in fitness to practise cases. However, it was widely acknowledged by participants that such cases were closely interlinked with dishonesty and thus expressed as that, instead of 'candour'. Lack of candour was also associated with poor communication and working relationships.
- 5.30 There were concerns in the discussion groups about how fitness to practise committee members would distinguish between candour and dishonesty in allegations, and whether this could be perceived as introducing 'different grades of dishonesty'. It was noted by some that there was already some confusion in this area as between the varying terminology in charges such as 'dishonest' and 'misleading'.
- 5.31 A second challenge of prosecuting candour cases discussed in the groups related to the evidence gathering process. For example, candour cases might relate to what a professional thought or knew at a particular time (in other words, their state of mind), or exactly what they did (or did not) say to a patient on a particular day. This could make some cases of this type difficult to prove. It was suggested that candour cases could relate to circumstances where it is difficult to separate an individual's lack of candour from broader systemic issues. As noted above, it was also observed that sometimes a lack of candour might not emerge until well after the primary failing occurred.
- 5.32 One organisation noted in its questionnaire response that it did not support regulators becoming 'habitually involved in enforcing the process side of candour'. It suggested that regulators should be focused on dishonesty and lack of competence because there is a risk that if candour charges are added to clinical error charges, the response to a mistake will 'look disproportionate and punitive upon one individual and make practitioners even less likely to want to admit to mistakes'.
- 5.33 The GOC and PSNI both noted in their questionnaire responses that they have provided training on the duty of candour. The GOC did this with its case examiners and its fitness to practise committee members, whilst the PSNI told us that it recently held fitness to practise training for its Scrutiny and Statutory Committee members, in which it addressed the duty of candour and the role that Committees can play in ensuring the right allegations are brought before them based on the evidence presented. Some discussion group participants said there had been training which addressed candour for those involved in fitness to practise.
- 5.34 Although focusing on candour of professionals to regulators rather than patients, one stakeholder commented that fitness to practise processes are increasingly

encouraging registrants to be candid to regulators: the HCPC and the NMC have worked a great deal around early engagement with registrants referred in the fitness to practise process. The organisation considered that overall there had been a move by regulators, although with some inconsistency, from an adversarial approach to encouraging registrants to be open and honest.

- 5.35 The NMC observed that if success of encouraging candour is measured in terms of lowering the volume of fitness to practise cases involving lack of candour, it is too early to tell as it only recently started recording this level of detail and is not in a position to comment on any trends at this juncture. On the other hand, if success is measured as an increase in the number of registrants being candid to patients, this would pose an issue of how to measure since registrants who are candid are less likely to be referred to the fitness to practice process. Therefore, there is little fitness to practise data on professionals who have been candid. This means that although the amount of lack of candour can be measured, there may be potential issues with how to weight this against the prospect that professionals are being candid.
- 5.36 One stakeholder suggested that there had been a weakening in medical professionals' trust of the GMC due to the Bawa-Garba case. This meant that professionals had concerns over 'why and how they should be candid'. It was noted that it would take several years for the GMC to regain lost trust, despite the fact that the concerns arose around the possible misuse of reflective notes rather than the duty of candour. A number of other stakeholders made clear that professionals' concerns over misuse of reflective notes could hinder their compliance with the duty of candour. Relatedly, there was concern that regulators can often be seen as on the 'patient's side' and act punitively towards registrants.
- 5.37 One organisation noted that it was not aware of either the GMC or the NMC generating publicity about the cases where fitness to practise sanctions were applied in connection with the duty of candour. Publicity around sanctions could set an example to other registrants.
- 5.38 In Appendix C of this report we have listed candour-related fitness to practise statistics relating to the GMC, NMC and other regulators.

Engaging with registrants and wider stakeholders

- 5.39 The GMC engages with its registrants in England through its Regional Liaison Service team who deliver sessions on candour. The sessions, developed with South London's Health Innovation Network, cover both organisational and professional duties of candour, aiming to help professionals and organisations understand what they are required to do. The GMC has delivered 34 sessions⁵⁷ in Scotland on raising concerns (which incorporates candour) and worked closely with the Scottish Government as it has introduced its organisational duty of candour. The GMC was praised by one professional body for delivering 'useful' workshops on its candour guidance. Related to the Scottish duty of candour, one educational organisation noted that the NMC and the HCPC collaborated with the

⁵⁷ Between January 2015 and May 2018.

organisation and the Scottish Government to so support the launch of the duty of candour.

- 5.40 The PSNI, in response to the Hyponatremia Inquiry, published an article in its regulatory newsletter about the importance of the duty of candour in the context of the Inquiry's findings.⁵⁸ Candour was covered in the GOsC's magazine, *The Osteopath*, in late 2014. The magazine explained the professional duty of candour, what was expected of registrants and work the GOsC was doing on candour.⁵⁹ Since then, the GOsC has covered candour in the magazine in 2015, 2016 and 2018. When the HCPC revised its standards, making key changes related to the duty of candour, it relayed these changes through sending hard copies of the revised standards to every registrant, hosting tweetchats, publishing blog pieces and highlighting the changes in newsletters. The GPhC has published an article with case studies on good practice when making mistakes⁶⁰ and a 'reminder' to the pharmacy profession of their duty to be open and honest in the wake of the February 2018 Bawa-Garba court decision.⁶¹ The GOC published an article in *Optometry Today* in 2018 explaining the professional duty of candour and how optometrists and dispensing opticians can apply it in practice.⁶²
- 5.41 The GDC set up an advice line for dental professionals who needed support in raising an issue with a patient or about a colleague or other systemic issue. The line is hosted separately from the GDC by Public Concern at Work. The GDC told us that analysis of the available data shows that it is used by a range of registrant groups and that the majority of calls relate to patient safety issues.
- 5.42 The regulators have worked with stakeholders across health and social care to embed candour, for example, with system regulators. The NMC and the Care Quality Commission have a joint protocol which outlines the requirements of the duty of candour, how this relates to both healthcare professionals and providers, and how concerns can be raised with either regulator.⁶³
- 5.43 The regulators have also worked with a broad range of stakeholders beyond regulation in order to embed candour. The NMC discussed that in order to draft its new standards for consultation and embed candour, it engaged with educators, education commissioners, academic education institutions, practice placement providers, students, service users, other professional bodies and registrants. The GMC has developed local relationships with which it can promote messages of candour and attempt to resolve concerns when there are local cultural issues, these relationships include Directors of Medical Education, Freedom to Speak Up Guardians, Health Education England and others. When consulting on including changes to its standards, some relating to candour, the HCPC engaged with educators, service users and carers, professional bodies and voluntary sector

⁵⁸ Pharmaceutical Society of Northern Ireland (2018). [Regulatory Update](#)

⁵⁹ General Osteopathic Council (2014). [The Osteopath](#).

⁶⁰ General Pharmaceutical Council (2017). [Focus on responding and learning when things go wrong](#)

⁶¹ General Pharmaceutical Council (2018). [GPhC responds to concerns raised by pharmacy professionals in relation to the case of Dr Bawa-Garba](#)

⁶² Optometry Today (2018). [Being candid](#)

⁶³ Nursing and Midwifery Council and Care Quality Commission (2017). [Updated Joint Working Protocol NMC and CQC](#)

organisations. Additionally, the HCPC noted that it raises the issue of candour at regular events it holds for employers.

- 5.44 The GOsC raised the issue of candour with the osteopathic professional body, the Institute of Osteopathy, which has included a reference to candour in its *Patient Charter*. ‘Your osteopath will be honest and open with you should anything go wrong while they are caring for you’.⁶⁴
- 5.45 Finally, the GDC and the GOsC have jointly worked to understand patient and professional views on how the two groups can have better discussions and shared decision-making. Candid and full conversations can be useful to establish clear expectations for patients, which can be especially important when a treatment may have a cosmetic element and may involve significant costs. This joint work will contribute to the development of a toolkit.

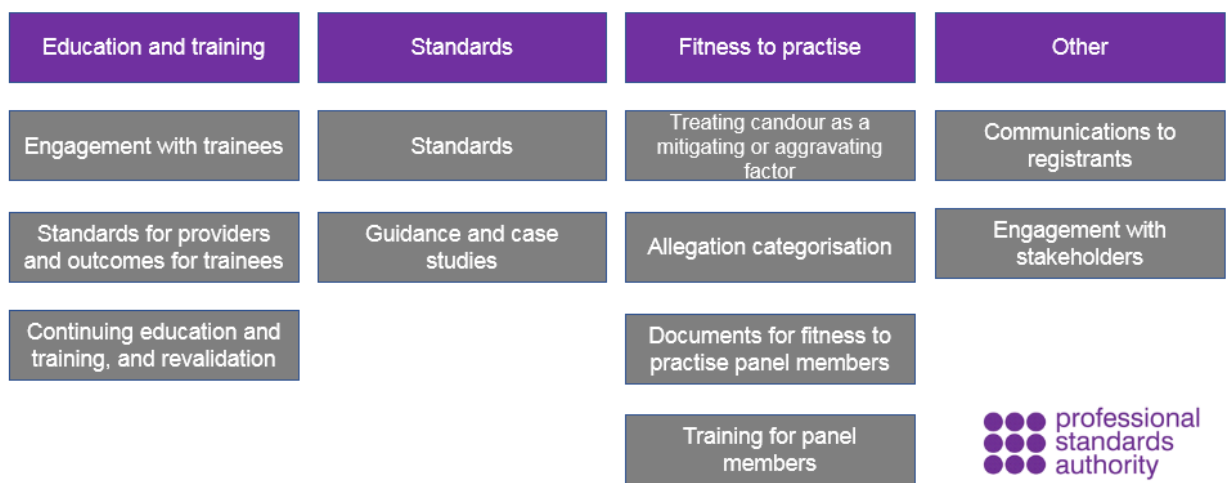


Figure 5: Regulatory tools for understanding and encouraging candour

⁶⁴ The Institute of Osteopathy, [The Patient Charter](#)

6. What more can regulators do to encourage candour?

- 6.1 Stakeholders and regulators had a variety of suggestions of how candour could be better encouraged across the health and care sector. For example, a complaints body noted that many people who bring their unresolved complaints about healthcare to the organisation, do so because they are dissatisfied with the local complaints response and are seeking an apology as an outcome. Therefore, the organisation suggested that there is perhaps more that healthcare providers and professionals can do to offer apologies promptly when something has gone wrong. Further suggestions about how non-regulatory organisations could encourage candour, include (in a non-exhaustive list):
- An improvement in the structure and working environment of clinicians to support clinicians who may work in a defensive culture and with high workloads
 - Increased engagement by boards and Trusts with frontline staff in order to listen to their concerns
 - Time set aside for professionals to reflect upon experiences and discuss and review those experiences with peers
 - Insurers reducing insurance premiums for those who are candid and fining those who do not comply with the duty of candour.
- 6.2 However, this paper is focused on what professional regulation can do to encourage candour. The following chapter thematically organises those suggestions around how candour can be encouraged by professional regulators.

Case studies

- 6.3 A general theme emerging from the data we have collected is that candour is highly contextual; it is influenced by varying factors ranging from workplace cultures to inter-professional relationships. It was suggested by one participant that unless candour was anchored in the realities of professionals' working lives it risked 'just becoming another aspirational standard'. It was posited that case studies can demonstrate how the duty of candour could work in practice. The participant observed that case studies can be relatable and interesting for professionals as 'people read stories about other people' and that findings from real life cases tend to get more 'hits' online than rule-based guidance documents. The GCC pointed out there is too much guidance for professionals but that maybe some case studies, practical tools and resources are needed to 'bring this issue [candour] to life'. It noted that this type of work had been well-received on the subject of conflicts of interest.⁶⁵ It was also noted by discussion group participants that cases studies could be useful to communicate messages of candour to the public, as well as professionals.

⁶⁵ For example, [Competing interests and incentives](#), GMC and [Joint statement from the Chief Executives of statutory regulators of health and care professionals](#), NMC.

- 6.4 Additionally, one stakeholder mentioned that best practice should be shared as well as examples of when candour is not ‘delivered well’. There may even be a role for the Professional Standards Authority, as one participant suggested, to make use of its database by collating cases where candour has been an issue and looking at how they have been dealt with. Respondents noted there was potential for more use of positive examples of candour. The HCPC noted that positive examples of the benefits of candour to patients could help to more generally encourage candour.
- 6.5 We learnt earlier (paragraph 4.8) that a barrier to candour could be professionals lacking belief that being candid will have a meaningful outcome. Case studies with a positive outcome may help to alleviate this issue.

Patients and public

- 6.6 The HCPC’s patient-orientated suggestion at paragraph 6.4 is a significant one – when a professional is being candid there are usually two parties involved: professionals and patients. Much of the evidence in this paper has been oriented around the vantage point of professionals, with little focusing on patients’ perceptions of issues of candour. A firm of solicitors responding to our call for information, noted that patients often describe ‘feeling ignored or let down whilst struggling to access information regarding their treatment and it is this frustration which is often repeated upon solicitors’ first contact with clients’. Another firm observed that, although clinicians may admit to something going wrong in the care of a patient, they do not always provide enough details to answer all the patient’s questions, and patients are not given sufficient information to understand when negligence has occurred. It could be useful to better understand what patients think about candour, such as above, to better understand what patients want from candour.
- 6.7 One discussion group participant noted that training providers need to make professionals understand how the public feel when professionals have been candid. It was suggested by respondents that regulators could make use of patients’ and carers’ feedback in campaigns. It was also pointed out in questionnaire responses that practitioners should be made aware of the ‘positive impact on patients of early acknowledgment and communication of errors’. for example, the GOC’s guidance to its registrants notes the impact of an apology on patients: ‘Offering an apology is an important part of being candid as it shows that you recognise the impact of the situation on the patient and that you empathise with them’.⁶⁶
- 6.8 One professional body considered it would be useful for the regulators to make the public aware that mistakes happen. This should also involve explaining that professionals attempt to minimise the risk of repeated errors.

Positive candour

- 6.9 When candour is discussed at the moment, it is frequently viewed from the negative vantage point of when a professional is lacking in candour. A significant number of questionnaire respondents and discussion group participants thought

⁶⁶ General Optical Council. [Candour guidance: Be candid when things have gone wrong](#), paragraph 20.

there was an opportunity for regulators to focus more on when a professional has been candid to a patient, or 'positive' candour. One stakeholder noted:

'We believe it would be counter-productive to emphasise the 'stick' of regulatory compliance by trying to place even greater importance on what regulators require when there is a rather more effective 'carrot' of educating professionals and explaining that being candid is an important part of their job and central to maintaining a professional relationship with patients'

- 6.10 Interestingly, the imagery of 'stick' was also used by three other organisations responding to the questionnaire and one discussion participant. The latter described fitness to practise as a 'big blunt stick' in encouraging candour amongst professionals. The discussion participant saw merit in regulators working more with education bodies and employers to encourage candour. A reshaping of the way candour is discussed could be useful in encouraging candour, as the GOsC puts it: 'avoiding a discourse which is based around fitness to practise rather than seeing candour as a positive professional attribute'.
- 6.11 A number of stakeholders commented that when the duty of candour has a positive outcome there should be recognition of this, which can be shared widely. This can then be a positive learning experience not only for professionals but also for organisations. The GPhC was praised by one body for how its documentation of fitness to practise cases can promote learning but noted there was room for more positive stories. With the facts of these cases at their fingertips, pharmacists and pharmacy technicians can apply this to their own situations.
- 6.12 Although these comments emphasise that dialogue should move away from being based around fitness to practise in order to be more positive, fitness to practise does have some means to offer positive perspectives of candour. For example, in a fitness to practise hearing candour could be a mitigating factor which could be a case study for explaining the merits of candour to professionals. Discussion participants noted that there are limits to positive candour, in that weight attached to a candour mitigation would depend on the underlying facts of the case.
- 6.13 The ability to be candid should be seen as an important asset for professionals' practice. Generally, healthcare professionals have a high level of trust amongst the public. However, this trust can easily disappear if honesty and openness is lacking. One firm of solicitors noted:
- 'Many patients who contact us seeking legal advice regarding a potential negligence claim state that they had previously had a high level of confidence in their doctors (even when things may have gone wrong) but that it disappeared quickly in the absence of openness and honesty regarding their injury'*
- 6.14 There may be merit in seeing candour as contributing to maintenance of public trust in professions. One regulator suggested that there should be 'encouragement for seeing candour as a professional strength not a cause for concern'. Therefore, being a trusted professional should mean being expected to be candid.
- 6.15 Discussion group participants often returned to the need for the right balance in the regulatory response to cases involving candour. Although there was

widespread support amongst participants of positive steps to encourage candour by regulators, (through education and promotion at a local level), some participants discussed the role of fitness to practise proceedings in sending out a clear message to professionals and the public about the importance of being candid.

- 6.16 The GDC noted to us that it is committed to re-focusing its regulatory activities ‘upstream’ as set out in *Shifting the balance*.⁶⁷ Part of this means promoting professionalism at an early stage in the careers of dental professionals, for example whilst they are still in education and training. As part of the work arising from *Shifting the balance*, the GDC has established an active programme of student engagement. As this programme develops, the student engagement will be part of a drive to promote professionalism and encourage candour. The GDC is also in the process of scoping a programme on ‘Promoting Professionalism’ to engage current registrants to embed the standards in their everyday practice and to encourage other organisations to use their influence on registrants to drive positive behaviour.

Working with other organisations

- 6.17 As we saw in the last chapter, regulators are limited in how much they can affect the candour of registrants. We received a number of suggestions of how regulators could work with other stakeholders. For example, candour could be better embedded and clarity increased about the two duties of candour by professional regulators working closely with system regulators. Working closely with system regulators could also include training for professionals and organisations to improve communications skills, enabling clinicians to have challenging conversations and dispelling fears about the legal ramifications of apologies.
- 6.18 We asked all organisations in the questionnaire ‘How does your organisation encourage professionals to behave candidly?’, the responses showed that a number of organisations beyond regulation have initiatives to encourage candour in individuals. For example, one educational body told us that it has developed an online learning module on the duty of candour, whilst a trade union described how it has delivered training to members and non-members on the statutory and professional duty of candour. There may be scope for regulators to learn from and work with other organisations providing advice on candour.
- 6.19 The GMC suggested it would be useful for ‘key players’ in the sector (regulators, employers, doctors) to work together to influence a cultural shift from ‘blame’ to ‘learning’, it noted that smaller behavioural changes such as improving communication skills of healthcare professionals can contribute to this culture change.

Common approach of regulators

- 6.20 One stakeholder considered it would be useful to have ‘one joined-up clear vision of candour’. Another organisation suggested that it would be timely for regulators to review and promote the joint statement of 2014 and consider how the statement

⁶⁷ General Dental Council (2017). [Shifting the balance: a better, fairer system of dental regulation](#)

could be more effectively disseminated and embedded. A separate organisation noted that its primary concern, regarding what regulators can do to further encourage candour, was that professionals should not find that compliance with the duty of candour leads to them facing arbitrary repercussions for exercising their duties. It welcomed a clear statement by professional regulators that this would not be the case.

- 6.21 Relatedly, the GOC considered that regulators had appeared recently to be working together more closely and this would help tease out new means of communicating the duty of candour to registrants. It went further and noted that collaboration between regulators could aid collective learning and that a 'cohesive and collaborative approach' on the part of regulators and stakeholders is required to allay concerns and encourage a cultural shift across the professions to be more candid. One professional body suggested that regulators can work collaboratively to better reflect the integrated and interprofessional contexts in which professionals work. It is also noted that an educational organisation noted that consistency of applied thresholds for candour is 'key across health and social care regulators'. Meanwhile, another stakeholder noted that given the current priorities around regulatory reform and regulators reviewing their processes, it would be essential for activity to be aligned to 'outline a common set of care values and standards throughout the patient journey'.
- 6.22 One discussion group participant thought that collaboration between regulators 'saves resources' and that it may be useful to explore the idea of an interprofessional teaching module. Overall, discussion group participants viewed there to be many commonalities over candour between the regulators and room for more consistency and collaboration.
- 6.23 One membership body stakeholder told us that its members considered there to be a large volume and range of guidance on candour available. They noted the benefits of having a 'single source of truth' to ensure clarity of process is shared across professional groups. This echoes another stakeholder's comment that it would be helpful to 'have one joined-up clear version of candour' across all regulators.
- 6.24 In 2014 we advised the Secretary of State that regulators should: 'be encouraged to sign up to a joint statement declaring their support for and expectation that their registrants meet a professional duty of candour with a commitment to moving towards a common standard over time'.⁶⁸ We noted then that a common standard 'could help to redress some of the differences between the professions' approaches to candour'.⁶⁹ We still consider a common standard to be a useful means to encourage as it could help resolve tensions arising from divergent professional approaches, which may have an important contribution to multi-disciplinary working. It might also provide an opportunity to clarify expectations and thresholds between the organisational and professional duty of candour.

⁶⁸ Professional Standards Authority (2013). [Can professional regulation do more to encourage professionals to be candid when healthcare or social work goes wrong? Advice to the Secretary of State](#) pp28-9.

⁶⁹Ibid, p9.

Fitness to practise

- 6.25 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’, suggested one professional body. It suggested that an act of candour should receive recognition when a professional is facing a sanction or being investigated. This echoes the comments earlier in this report of an educational body (paragraph 4.19) that suggested regulators have a role in ‘destigmatisation of those that disclose failings’. A few organisations considered that regulators could provide more clarity about how candour would be dealt with in fitness practise processes. One organisation suggested regulators could do more to encourage candour by ‘providing clear guidance’ on what ‘factors will be considered’ when candour was dealt with in fitness to practise. Another organisation called for regulators to create guidance that gives professionals ‘a clear and rounded view of how regulators factor candour into their decisions’.
- 6.26 One stakeholder suggested that if a regulator receives a referral from an employer of a professional who has made an error, the regulator could take into account how much training, mentoring and other support the professional has received from their organisation, which can affect the professional’s levels of candour.
- 6.27 The NMC’s draft future fitness to practise strategy was viewed positively by one stakeholder, as it considered that the emphasis on context and taking into account whether an environment allows for reflection by a nurse or midwife could encourage better compliance with the duty of candour.

Guidance

- 6.28 In paragraph 5.9 we learnt that a stakeholder perceived there is a lack of specificity in the NMC code and guidance, which can mean it is harder for professionals to comply with the duty. The same professional body proposed that regulators and the Authority could make ‘clearer, less open-ended guidance so that health professionals have the confidence to comply that comes from clarity about the expectation on them’.
- 6.29 A professional body suggested that there needs to be more clarity on the relationship between ‘when something goes wrong’ and ‘distress in the professional duty of candour’. Currently, the joint statement says:

‘Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress’

- 6.30 The organisation pointed out that distress is a wide term and there is no clarification in the duty of candour about whether this should be assessed objectively (‘by reference to what a reasonable person would find distressing’) or subjectively. It also noted that distress can be caused by many factors in a healthcare environment, which may or may not be in the control of professionals. The organisation noted an example of this sort of difficulty, provided by one of its members:

‘Where an appropriate referral to hospital for further investigation results in the patient being told there is no problem, and the patient (who may

understandably have been distressed by the very act of referral) then demands an admission that the professional who made the referral has got things wrong'

- 6.31 The organisation noted that regulators' guidance would be the appropriate vehicle to deal with this kind of scenario and 'expand on what the regulators consider as amounting to distress which engages the duty of candour'. This example emphasises the potential helpfulness of using case studies.

Education and training

- 6.32 One stakeholder suggested that an outcome on understanding and applying principles of 'courage, transparency and the duty of candour' should be included in undergraduate learning in education institutions and practice placements. They said that this was because it is an 'important foundation for embedding candour' and pointed to the fact that the outcome is currently included in the NMC's *Future Nurse: Standards of proficiency for Registered Nurses*.⁷⁰ The same stakeholder also recommended that the HCPC should explicitly include 'duty of candour' in its Standards of Education and Training (SETs)⁷¹ so each health education institution is required to outline when this is covered and by what methods. It also suggested that this should link to the HCPC's fitness to practise regulations and processes.
- 6.33 One education organisation called for education of the duty of candour to have a mandatory place in all health and social care professional education and training to be supported by professional regulators. It also noted that this should be delivered interprofessionally. It also noted that there should be interprofessional training sessions for students to make them aware of each other's skills, knowledge and expertise. This could help students understand the value of all different professionals on a team, which can make them feel valued and thus have the confidence to be candid when they have qualified.

Data

- 6.34 One respondent recommended regulators could make more use of data to not only identify organisations that appear to have a high referral rate but also to raise issues with the system regulators for further investigation. Additionally, withstanding the limits of measuring candour through regulatory data, good use of data could help illustrate candour issues for professionals.

Interprofessional working

- 6.35 Stakeholders noted that there could be a role for different professional groups to work together to embed candour. One respondent organisation observed that receiving a complaint can be challenging and even distressing for a healthcare professional. The organisation noted that it had seen examples of NHS organisations addressing complaints received by individuals at multidisciplinary team meetings and working together to respond to these. By focusing on learning,

⁷⁰ Nursing and Midwifery Council (2018). [Future nurse: Standards of proficiency for registered nurses](#)

⁷¹ Standards of education and training. Standards against which the HCPC assesses education and training programmes.

rather than individuals and blame, this can offer a means to support and incentivise individuals to admit mistakes.

- 6.36 An educational organisation commented that ‘the increasing clinical model of multi-professional teams will need to be taken into account by regulators and employers’. Regulators may even have a role in fostering candour through interprofessional working. One education organisation suggested that professional regulators could work together to emphasise the need for interprofessional candour, noting that ‘where a mistake has been made by an interprofessional team the patient and family need to understand what has happened in a connected way and to receive information and support which reflects everyone in the team’.
- 6.37 Additionally, one professional body thought that it could be useful for the regulator relevant to their profession to reach out to other professional groups to ‘ensure candour is the responsibility of all professionals involved in patient care or service delivery’.

7. Conclusions

- 7.1 We have seen in this paper that the regulators have made wide-ranging efforts to embed candour. These include but are not limited to: introduction of candour-related standards, creation of candour guidance, inclusion of candour in fitness to practise documents and embedding candour in education and training. Regulators can both promote and encourage ‘positive candour’ and also express their disapproval where professionals have not been candid. As discussion participants suggested, regulators need to strike a balance in their approach to how they deal with candour.
- 7.2 There is much good practice by the regulators. Examples of good practice within this paper provide an opportunity for regulators to learn from each other. There may also be scope for regulators to collaborate more on candour to increase their effectiveness.
- 7.3 These positive examples could set out the benefits of being candid to patients. This paper has seen a few examples of when an organisation, not just regulators, explains why candour is a positive attribute. There are a range of benefits to patients from candour by professionals, for example an apology can foster ‘mutual trust and respect which forms the bedrock of the professional relationship’.⁷² We saw earlier that the GOC pointed out that an apology can show that a professional recognises the impact of the situation on a patient and that they empathise with the patient.⁷³ It has been suggested in other literature an apology can have ‘profound healing effects’ for professionals as well as patients as it can ‘help diminish feelings of guilt and shame’ in professionals in addition to facilitating forgiveness and create a foundation for reconciliation in patients.⁷⁴ One discussion participant talked about how the process of being candid has the capacity to be a ‘cathartic’ experience and can feel like a ‘weight lifted’.
- 7.4 It is difficult to work out how successful the regulators have been at encouraging candour given candour is hard to measure and the range of factors which affect a professional’s candour to patients – we discussed these issues in chapter 3. The views of stakeholders were mixed about the progress of regulators: some considered regulators to have made progress, others reflected that there had been little progress, whilst a number of stakeholders did not hold a view or found it difficult to attribute progress in embedding candour across health and social care to professional regulators.
- 7.5 Difficulty in understanding the effects of regulation is further tempered by the fact that it takes time to change cultures, as noted by a few organisations. One of these organisations said that regulators are limited by timescales for processes to ‘bed in and roll out’. It will take time to understand comprehensively the effects of changes to standards, education, fitness to practise and other areas.

⁷² Devlin, M. (2015). [Duty of candour—make apologising easy](#), British Medical Journal

⁷³ General Optical Council. [Candour guidance: Be candid when things have gone wrong](#), paragraph 20.

⁷⁴ MacDonald, N and Attaran, A. (2009). [Medical errors, apologies and apology laws](#) Canadian Medical Association Journal.

7.6 The paper has shown that although regulators have a role in encouraging and embedding candour, they are limited in their contribution. We suggest that it is necessary for organisations and individuals from across health and social care to work together to produce professionals who are candid to patients and work in environments that do not stymie that candour. Professionals need to, as discussion participants observed, 'take candour to heart'. The encouragement of organisations across healthcare can enable that, making candour a professional strength to be valued, not just a regulatory requirement to be complied with. As one professional organisation noted in chapter 4: the duty of candour is 'less to do with a culture of compliance and more to do with a culture of responsibility'. This paper has seen that regulators have relationships with key stakeholders, such as locally with employers and 'upstream' with education and training organisations. For candour to be embedded, regulators could further strengthen those relationships, working with and learning from other organisations working to encourage candour. For example, regulators working with employers and system regulators may help support trainees transitioning into the workforce to ensure positive reinforcement of skills learnt during training so they are not negatively impacted by environments with poor records of candour.

7.7 To summarise this paper, we make the following main conclusions:

- It would be useful to learn more about the benefits of candour from the perspectives of patients and different segments of the public.
- Many of the barriers to professionals being candid remain the same as in 2014 when we last did work in this area and the research we recommended has not been carried out.
- The capacity of individuals to be candid is highly influenced by the environment they work in. Influencers in that environment include the wider culture of an organisation, team members and non-clinical staff.
- Regulators have made progress with initiatives to encourage candour. However, measuring the success of these initiatives is difficult and no reliable method has yet been developed.
- There is support for more case studies of candour scenarios. This would help to better explain to professionals when to be candid and the regulatory consequences of not being candid.
- Candour does not appear in the determinations of regulators but they consider it is catered for in other charges like 'dishonesty'. Most regulators do not have a category for it as an allegation type. Interprofessional working may help to create a culture of candour and candid professionals. Regulators could consider how they might use their role in quality assuring education to better enable interprofessional working
- It may be useful for regulators to consider creating a 'regulatory space' in which professionals can be candid, this may be through tools such as consensual disposal and continuing fitness to practise.
- Issues of candour are shared across professions; there is scope for regulators to work together to solve these issues. A common standard applied across all

regulators could be a useful means to redress differences between professions over approaches to candour.

- Successful embedding of candour requires organisations across healthcare (not just regulators) to work together. Candour may be better embedded by regulators forging strategic relationships across the health and social care industry.

7.8 It is perhaps the last point that is the most critical for understanding regulation's role in encouraging candour. This report has shown that there is not one way to embed a culture of candour, instead regulators, professional bodies, providers and education bodies need to work together.

8. Appendix A – Standards

8.1 Below are the standards of regulators, which are directly relevant to a professional when something has gone wrong in a patient's care.⁷⁵

Regulator	Standards relating to candour
GCC	B7. [You must] Fulfil the duty of candour by being open and honest with every patient. You must inform the patient if something goes wrong with their care which causes, or has the potential to cause, harm or distress. You must offer an apology, a suitable remedy or support, along with an explanation as to what has happened. ⁷⁶
GDC	1.3.1 You must justify the trust that patients, the public and your colleagues place in you by always acting honestly and fairly in your dealings with them. This applies to any business or education activities in which you are involved as well as to your professional dealings. 2.2.3 You must give full and honest answers to any questions patients have about their options or treatment. 5.3.8 You should offer an apology and a practical solution where appropriate. ⁷⁷
GMC	You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should: <ul style="list-style-type: none"> a. put matters right (if that is possible) b. offer an apology c. explain fully and promptly what has happened and the likely short-term and long-term effects.⁷⁸
GOC	<i>Optical professionals</i> 19. Be candid when things have gone wrong 19.1 Be open and honest with your patients when you have identified that things have gone wrong with their treatment or care which has resulted in them suffering harm or distress or where there may be implications for future patient care. You must: 19.1.1 Tell the patient or, where appropriate, the patient's advocate, carer or family) that something has gone wrong. 19.1.2 Offer an apology.

⁷⁵ We note that regulators may also have additional standards which deal with contributing to a workplace where professionals can be open. For example, the GDC's '8.3.1 You must promote a culture of openness in the workplace so that staff feel able to raise concerns'.

⁷⁶ GCC, [The Code Standards of conduct, performance and ethics for chiropractors](#)

⁷⁷ GDC. [Standards for the Dental Team](#)

⁷⁸ GMC. [Domain 4: Maintaining trust](#)

	<p>19.1.3 Offer appropriate remedy or support to put matters right (if possible).</p> <p>19.1.4 Explain fully and promptly what has happened and the likely short-term and long-term effects.</p> <p>19.1.5 Outline what you will do, where possible, to prevent reoccurrence and improve future patient care.</p> <p>19.2 Be open and honest with your colleagues, employers and relevant organisations, and take part in reviews and investigations when requested and with the General Optical Council, raising concerns where appropriate. Support and encourage your colleagues to be open and honest, and not stop someone from raising concerns.</p> <p>19.3 Ensure that when things go wrong, you take account of your obligations to reflect and improve your practice as outlined in standard 5. [keeping knowledge and skills up to date]⁷⁹</p> <p><i>Optical students</i> 18. Be candid when things have gone wrong</p> <p>18.1 Be open and honest with your patients when you have identified that things have gone wrong with their treatment or care which has resulted in them suffering harm or distress or where there may be implications for future patient care, seeking advice from your tutor or supervisor on how to proceed. They will advise on whether further action is required such as:</p> <p>18.1.1 Telling the patient (or, where appropriate, the patient's advocate, carer or family) that something has gone wrong.</p> <p>18.1.2 Offering an apology.</p> <p>18.1.3 Offering appropriate remedy or support to put matters right (if possible).</p> <p>18.1.4 Explaining fully and promptly what has happened and the likely short-term and long-term effects.</p> <p>18.1.5 Outlining what you will do, where possible, to prevent reoccurrence and improve future patient care. 18.2 Be open and honest with your supervisor or training provider and take part in reviews and investigations when requested and with the General Optical Council, raising concerns where appropriate. Support and encourage your peers to be open and honest, and not stop someone from raising concerns.</p> <p>18.3 Ensure that when things go wrong, you reflect on what happened and use the experience to improve.</p>
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⁷⁹ GOC. [Standards of Practice for Optometrists and Dispensing Opticians](#)

GOsC	<p>D3. You must be open and honest with patients, fulfilling your duty of candour.</p> <ol style="list-style-type: none"> 1. If something goes wrong with a patient's care which causes, or has the potential to cause, harm or distress, you must tell the patient, offer an explanation as to what has happened and the effects of this, together with an apology, if appropriate, and a suitable remedy or support. 2. You must also be open and honest with your colleagues and/or employers, where applicable, and take part in reviews and investigations when requested.⁸⁰
GPhC	<p>Standard 8: People receive safe and effective care when pharmacy professionals:</p> <ul style="list-style-type: none"> • promote and encourage a culture of learning and improvement • challenge poor practice and behaviours • raise a concern, even when it is not easy to do so • promptly tell their employer and all relevant authorities (including the GPhC) about concerns they may have • support people who raise concerns and provide feedback • are open and honest when things go wrong • say sorry, provide an explanation and put things right when things go wrong • reflect on feedback or concerns, taking action as appropriate and thinking about what can be done to prevent the same thing happening again • improve the quality of care and pharmacy practice by learning from feedback and when things go wrong.⁸¹
HCPC	<p>8.1 You must be open and honest when something has gone wrong with the care, treatment or other services that you provide by:</p> <ul style="list-style-type: none"> – informing service users or, where appropriate, their carers, that something has gone wrong; – apologising; – taking action to put matters right if possible; and – making sure that service users or, where appropriate, their carers, receive a full and prompt explanation of what has happened and any likely effects.⁸²

⁸⁰ GOsC. [Osteopathic Practice Standards](#)

⁸¹ GPhC. [Standards for pharmacy professionals](#)

⁸² HCPC. [Standards of conduct, performance and ethics](#)

NMC	<p>14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place</p> <p>To achieve this, you must:</p> <p>14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm</p> <p>14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers, and</p> <p>14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly.⁸³</p>
PSNI	<p>Standard 1.2: Uphold the duty of candour and raise concerns appropriately</p> <p>1.2.4 When something goes wrong with a pharmacy service, explain fully to the patient or service user what has happened, and where appropriate:</p> <ul style="list-style-type: none"> • offer an apology • offer an appropriate and effective remedy • explain the short and long term effects • provide support and assist to put matters right. <p>1.2.5 Be open and honest with patients, service users, colleagues, and employers when something goes wrong.⁸⁴</p>

⁸³ NMC. [The Code Professional standards of practice and behaviour for nurses and midwives](#)

⁸⁴ PSNI. [The Code: Professional standards of conduct, ethics and performance for pharmacists in Northern Ireland](#)

9. Appendix B – Standards for education and training providers

9.1 The table below shows candour specific standards of five regulators for education and training providers.

Regulator	Education standards relating to candour
GCC	<p>1.3. Recognise, understand and describe specific legislation relevant to the work of chiropractors, including ionising radiation.</p> <p>Guidance: This would normally include[...] duties imposed by law, such as the Duty of Candour</p> <p>6 Demonstrate an understanding of the nature of professional accountability.</p> <p>Guidance: This would normally include the ability to[...]fulfil the duty of candour.⁸⁵</p>
GDC	<p>6. Providers must ensure that students and all those involved in the delivery of education and training are aware of their obligation to raise concerns if they identify any risks to patient safety and the need for candour when things go wrong.⁸⁶</p>
GMC	<p>R1.4 Organisations must demonstrate a learning environment and culture that supports learners to be open and honest with patients when things go wrong – known as their professional duty of candour – and help them to develop the skills to communicate with tact, sensitivity and empathy.⁸⁷</p>
NMC	<p>At the point of registration, the registered nurse will be able to:</p> <p>1.3 understand and apply the principles of courage, transparency and the professional duty of candour, recognising and reporting any situations, behaviours or errors that could result in poor care outcomes⁸⁸</p> <p>Approved education institutions, together with practice learning partners, must:</p> <p>1.9 ensure students are supported and supervised in being open and honest with people in accordance with the professional duty of candour⁸⁹</p>

⁸⁵ GCC (2017). [Education Standards: Criteria for chiropractic programme content and structure](#)

⁸⁶ GDC (2015). [Standards for Education Standards and requirements for providers](#)

⁸⁷ GMC. [Promoting excellence: standards for medical education and training](#)

⁸⁸ NMC (2018). [Future nurse: Standards of proficiency for registered nurses](#)

⁸⁹ NMC (2018). [Realising professionalism: Standards for education and training Part 1: Standards framework for nursing and midwifery education](#)

GPhC	Pre-registration trainee pharmacy technicians will: '22. Act openly and honestly when things go wrong' ⁹⁰
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⁹⁰ GPhC (2017). [Standards for the initial education and training of pharmacy technicians.](#)

10. Appendix C – Fitness to practise statistics

- 10.1 We asked regulators: ‘How frequently do you receive fitness to practise complaints/referrals about candour failures? What proportion of these is closed in the earlier stages of your FtP process (ie. any stage before the final hearing stage)?’. The GOsC, GPhC, HCPC and PSNI did not produce data in response. This was for a range of reasons: no data available, categorisation does not cater for candour or no complaints or referrals relating to candour. The HCPC noted that it is currently developing its approach to case categorisation, and hopes to include categories such as: ‘failure to be open and honest’; ‘failure to recognise or report concerns promptly or appropriately’; and ‘failure to support, follow up or escalate concerns’.

GCC

Investigating Committee

- 10.2 The GCC does not have a specific category for ‘candour’ within its categorisation methods, as the word ‘candour’ may take in various issues that may form a complaint.

Professional Conduct Committee

- 10.3 In 2017, one PCC case related specifically to issues of candour. It is described in the footnote.⁹¹

GDC

- 10.4 The GDC does not have an explicit standard against which issues around candour are considered. It has looked at data under the standard ‘Put patients’ interests first’, then under ‘not acting honestly and fairly with patients’:

Decision date				
2014	2015	2016	2017	2018 Q1
95	83	136	130	45

GMC

- 10.5 The GMC told us that there have been at least of 322 complaints (see table below) received since 2014 (to 2017 inclusive) where there has been an allegation in

⁹¹ It was found proved by the PCC that the registrant had burnt the patient using a specific technique, known as ‘cupping’. The Committee then determined that if the registrant knew that he had burnt the patient then he was under a duty to inform the patient of this. The Committee noted that the registrant said that he told the patient that he had singed his hairs, but concluded that his duty, at that stage, was not to attempt to minimise what had occurred but to give the patient a proper explanation of what had occurred. The Committee was satisfied that he did not do so.

The Committee was satisfied that the registrant had failed to take even the most basic steps to minimise the extent of the burn and had said words to the effect of “...that’s nothing, put burn spray on it” and “you don’t need to go to hospital”.

The Committee concluded that the only potential breach of the Code was a breach of B7 (duty of candour) in that the registrant had not been as candid with the patient as he should have been. This case did not, however, lead to a finding of unacceptable professional conduct.

relation to duty of candour relating to paragraphs 23, 24 and 55 of Good Medical Practice 2013. The GMC only started recording allegations against enquiries closed at the triage stage in January 2017 and therefore allegations in relation to the duty of candour that were closed at the triage stage prior to 2017 are not captured below. This explains the significant increase in total complaints relating to the duty of candour in 2017.⁹²

Year of receipt of complaint	Total	Closed at triage	Closed at investigation	No further action	Advice	Warning	Undertaking	Refer to tribunal	In progress
2014	83	-	60	13	1	-	8	1	
2015	56	-	41	5	2	2	1	5	
2016	36	-	19	6	1	4	1	5	
2017	147	92	35	0	0	0	0	20	
Total	322	92	155	24	4	6	10	31	

GOC

10.6 The GOC told us that: ‘when opening an investigation, documents the primary and secondary standards that are potentially breached in a fitness to practice case. A failure to comply with their professional obligation to be candid could be measured using this data, for example since 1 April 2016, there are’:

Optometrists and Dispensing Opticians

- 7 out of 3912 cases have Standard 19 for as the primary standard breached
- 4 out of the 7 cases were self-referrals
- 1 case was in relation to misconduct (a summary of this case can be found at Question 7, case 2)
- 15 out of 3912 cases have Standard 19 for as the secondary standard breached
- 1 out of the 93 cases were self-referrals.

Student Optometrists and Dispensing Opticians

- 1 out of 3912 cases have Standard 18 as the primary standard breached
- 3 out of 3912 cases have Standard 18 as the secondary standard breached
- None of these cases were self-referrals.

⁹² The GMC further noted that the data above is correct as of 3 May 2018. Cases may have additional allegations added that relate to duty of candour up to the point of closure and therefore these figures are subject to change if new allegations are identified. The total is the minimum number received as the GMC only started recording allegations against enquiries from January 2017 and therefore enquiries related to duty of candour closed at triage prior to 2017 are not captured here.

NMC

- 10.7 In January 2017 the NMC introduced an allegations coding framework, which specifically includes codes relating to candour. Prior to January 2017 it was not possible to capture this data in a systematic way. The NMC's data on decisions and allegations coded at Case Examiner (CE) stage for the period of 1 April 2017 – 31 March 2018 is shown below.⁹³ The following tables provide a breakdown of duty of candour CE decisions.

Table 1. Duty of Candour allegations and case examiner decisions

CE decision	Total	% of total
Case to Answer	322	47
No Case to Answer	370	53
Total	692	

Table 2. Duty of Candour allegations that were case to answer decisions

CE decision	Case total	Allegation total
Refer to Fitness to Practise Committee	319	501
Recommend undertakings	3	3
Total	322	504

Table 3. Duty of Candour allegations that were no case to answer decisions

CE decision	Case total	Allegation total
No case to answer	322	398
Warning issued	44	61
Advice issued	4	7
Total	370	466

- 10.8 Between the introduction of allegation coding in January 2017 and March 2018, 449 cases were identified with a total of 566 duty of candour allegations. Of the cases, 345 cases resulted in a sanction. The table below summarises the number of cases and the number of allegations by sanction. A more detailed breakdown of outcomes by allegation can be found in table 5.

Table 4. Case outcomes by sanction

Sanction	Case total	Allegation total
Fitness to Practise impaired – striking off order	163	216

⁹³ The NMC notes that due to the coding and how this data is collected, it may include additional allegations that have not involved breaches of the legal duty of candour, but more general failures to be candid, either with patients, employers or the regulator.

The data is based on CE decision data, not referral rate, and therefore may contain a number of referrals made to the NMC prior to January 2017. The NMC does not hold complete allegations data for cases closed at screening in 2017.

Fitness to Practise impaired – suspension order	105	122
Fitness to Practise impaired – caution order	56	71
Fitness to Practise impaired – conditions of practice order	21	30
Total	345	439

Table 5 Count of Outcomes by Allegations level

Outcome	Allegation level one	Allegation level two	Total
FtP Impaired – striking off order	Dishonesty	Employment related dishonesty	105
		Patient care related dishonesty	52
	NMC registration and proceedings	Not disclosing NMC investigation to employer	19
		Not notifying NMC of criminal proceedings	9
		Not cooperating with NMC investigation	8
	Employment and contractual issues	Collusion to cover up information	8
	Management issues	Not reporting incidents and complaints	6
Communication issues	Not abiding by duty of candour	4	
	Not giving full or right information to patients and families	2	
Investigations by other bodies	Not cooperating with other investigations by healthcare regulator	2	
	Not cooperating with other formal investigations	1	
FtP impaired – suspension order	Dishonesty	Employment related dishonesty	48
		Patient care related dishonesty	37
	NMC registration and proceedings	Not cooperating with NMC investigation	13
		Not disclosing NMC investigation to employer	5
		Not notifying NMC of criminal proceedings	4
	Communication issues	Not giving full or right information to patients and families	5
		Not abiding by duty of candour	2
Management issues	Not reporting incidents and complaints	3	
Employment and contractual issues	Collusion to cover up information	2	
	Investigations by other bodies	Not cooperating with other formal investigations	2
		Not cooperating with other investigations by healthcare regulator	1
FtP impaired –	Dishonesty	Employment related dishonesty	32
		Patient care related dishonesty	19
	Management issues	Not reporting incidents and complaints	9

caution order	NMC registration and proceedings	Not cooperating with NMC investigation	3
		Not disclosing NMC investigation to employer	3
		Not notifying NMC of criminal proceedings	1
	Communication issues	Not giving full or right information to patients and families	1
FtP impaired – conditions of practice order	Investigations by other bodies	Not cooperating with other formal investigations	2
	Employment and contractual issues	Collusion to cover up information	1
	Communication issues	Not giving full or right information to patients and families	5
		Not abiding by duty of candour	2
Dishonesty	Patient care related dishonesty	10	
	Employment related dishonesty	6	
Investigations by other bodies	Not cooperating with police investigations	2	
	Not cooperating with other formal investigation	1	
NMC registration and proceedings	Not disclosing NMC investigation to employer	1	
	Not cooperating with NMC investigation	1	
Management issues	Not reporting incidents and complaints	1	
Grand total			439

11. Appendix D - Stakeholders who responded to questionnaires

Action Against Medical Accidents
Association of British Dispensing Opticians
Association of Optometrists
Barratts
British Dental Association
Care Quality Commission
Centre for Advancement of Interprofessional Education
Conference of Postgraduate Medical Deans
Faculty of Pharmaceutical Medicine
Good Clinical Practice Alliance – Europe
Health Education Improvement Wales
Hywel Dda University Health Board
Lincolnshire Partnership NHS Foundation Trust
Medical Schools Council
Medical Defence Union
NHS Education for Scotland
NHS Employers
NHS Resolution
Parliamentary and Health Service Ombudsman
Pharmacy Forum Northern Ireland
Royal College of Anaesthetists
Royal College of Emergency Medicine
Royal College of Nursing
Royal College of Paediatrics and Child Health
Royal College of Physicians of Edinburgh
Royal College of Physicians and Surgeons of Glasgow
Royal College of Physicians
Royal College of Surgeons
Royal College of Surgeons of Edinburgh
Royal Pharmaceutical Society

Unite the Union

Unison

Scottish Public Services Ombudsman

Social Care Wales

Strategic Initiative for Developing Capacity in Ethical Review

Waldrons Solicitors

Plus 11 individual members of the public and 4 organisations who did not want to be attributed.

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