

## **Scottish Public Services Ombudsman Response to the Consultation on Proposals to Introduce a Statutory Duty of Candour for Health and Social Care Services.**

If I have learned one thing from the SPSO experience of complaints handling, it is that openness and honesty are critical to repairing trust. And for health and social care services, trust is essential to good relationships with patients, their families and friends.

While trust does not come from legislation, but from personal relationships, I support the introduction of a statutory duty that places responsibility on organisations providing health and social care to ensure open and honest conversations can happen. In responding to this consultation, I provide some comments on our experience of a legislative approach to complaints, then comment in more detail on the duty of candour itself.

### **Our experience of legislative approaches to complaints handling**

It may seem counter-intuitive to support legislation to help change culture which is what is really needed for a duty of candour to work. However, our experience in the field of complaints handling supports the view that carefully worded legislation can provide the impetus for cultural change, even though it is not, in itself, sufficient to create this.

In 2010, the Public Services Reform (Scotland) Act gave us a new function, that of a Complaints Standards Authority. Our first task was to consult on Principles which were then approved by Parliament. This gave a strong signal about the importance Parliament placed on Complaints Handling. Over the next few years, working closely with individual sectors, we developed model complaints handling procedures for almost all of the public service in Scotland to implement a simple, standardised approach to complaints handling by public bodies. In particular, this encouraged the implementation of complaints culture more focused on frontline resolution and good governance, including better use of complaints information. We supported this by regular engagement with senior staff; developing and delivering training; providing additional support in response to questions; and helping to set up national networks to share best practice. We are currently helping to develop frameworks to allow for organisations and others assess their complaint handling arrangements, including the quality of complaints handling. This has already been used by Healthcare Improvement Scotland (HIS) in a draft format to help inform their assessment of complaints handling within a Board.<sup>1</sup> There is still work to be done but we have been very pleased at the way organisations across Scotland have embraced this work and we are already seeing a change in attitude towards complaints handling in many organisations.

I can identify a number of key reasons for this success. The fact that there was legislation was significant. Legislative requirements provide a way to get attention from senior members of staff, boards and regulators. They also provide levers to those inside an organisation who may wish to make changes. It is notable that about

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<sup>1</sup>[http://www.healthcareimprovementscotland.org/our\\_work/governance\\_and\\_assurance/programme\\_resources/ari\\_review.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme_resources/ari_review.aspx)

the same time as we were given legislative backing for this work, the Welsh Ombudsman was putting in place a voluntary scheme which has not had the same impact. We understand that the new Welsh Ombudsman is now seeking statutory backing for this.

However, legislation can have unintended consequences and I should emphasise that the legislation around complaints standards was carefully worded. It did not specify a process but, rather, set out broadly the way SPSO could develop a process. This is important, as legislation can stifle as well as support innovation. The enabling legislation that we have has provided that support. More restrictive legislation and, in particular, legislation which specifies process or practice can actually make things worse in our experience.

We also found that legislation alone would not work without the provision of tools to support change and oversight and the provision of practical assistance. In particular, we have found the ability of organisations to talk to our CSA team and to receive training from those with direct experience of complaints investigation has been important.

I should stress that this work did not require significant additional resources. We had, at most, 3 members of staff as full-time members of the CSA, a figure now standing at 2. Our training unit is also small, with one training co-ordinator and other staff providing additional support. There is, though, a need to ensure that the support is sustainable in the long term. While we needed more resource at the early stages, on-going resources are needed to ensure progress continues.. These are not short-term initiatives. Improving the way an organisation responds to mistakes and to complaints is something that regularly needs renewed.

### **Duty of candour – key steps to developing the approach to practice**

The approach in the consultation to the duty itself has similarities with work we have done on apology.<sup>2</sup> This emphasises the importance of honesty and provides a guide for those who want to be sure an apology is as full as possible. Indeed, the approach set out in the consultation including governance, reporting and oversight has strong resonance with our work on complaints and we note the reference in the consultation to existing processes. This is an important point I will turn to again below.

Being honest when things go wrong is not easy. Our model complaints handling procedures requires organisations to ensure they provide training and support to all staff who are likely to need to respond to complaints. We know some organisations have interpreted this widely and all front-line staff have been trained using our e-learning system. Our training includes training on apology and a section on dealing with difficult conversations – two areas that staff often find hard and which reflect issues they may also have in delivering a duty of candour. Training can help overcome barriers and provide practical tools but staff also need support from the organisation. When an individual is doing something difficult, they need to know they are supported. Placing an obligation on organisations to ensure that disclosure

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<sup>2</sup>[http://www.spsso.org.uk/sites/spsso/files/communications\\_material/leaflets\\_buj/2011\\_March\\_SPSO%20Guidance%20on%20Apology.pdf](http://www.spsso.org.uk/sites/spsso/files/communications_material/leaflets_buj/2011_March_SPSO%20Guidance%20on%20Apology.pdf)

happens should be seen as requiring them to provide an environment where staff are encouraged and enabled to disclose not one where they are punished for admitting to failings.

We worked closely with Healthcare Improvement Service when they were developing their adverse events guidance and, as the consultation recognises there is significant overlap between an open approach to adverse events and a duty of candour. I noted in the consultation on adverse events how rarely I find a structured internal clinical review has occurred when looking at a complaint. I would also like to highlight some points I made to HIS about their consultation on adverse events which I think are directly relevant to the successful implementation of any duty of candour.<sup>3</sup>

The first point is that in my experience reviews could be undermined by an overly-defined remit and a sense of working to the guidance or the procedure rather than working to the outcome. Staff become caught up in definitions and issues, such as who should be involved or who is allowed to know what is happening in a review, rather than seeing it as a chance to improve patient care and a normal and regular part of good clinical practice. This is a risk when any new procedure is brought in to place and avoiding it requires careful development of the legislation, process and guidance. Ideally, those implementing it should be involved as well as representatives of those who receive services. Staff ownership of the process must come not only from staff responsible for governance, but from those delivering the care. Guidance can set minimum standards and provide some assistance to staff who may be unsure how to proceed. It can, however be counter-productive if it becomes seen as “someone else’s responsibility” or becomes used as a way of allowing staff to rule out issues which do not strictly fall within key definitions, or to focus on the process and not the outcome. On this point, it is important that the statutory duty of candour interacts smoothly with professional obligations set out by the GMC and NMC.

This brings me to another point of importance. I have found that there can be confusion about how incident reviews relate to other processes, whether that is the complaints process or the work of other agencies. This led in some cases to a complaints process being used rather than a review conducted, or a review undertaken that looked at issues of significance to the organisation but did not answer the complaint made. As I explain in more detail below, the duty of candour cannot be an isolated duty and it should be clear from the start how it will relate with other processes already in place, including obligations on staff as individuals, as well as other patient feedback mechanisms.

I have reflected again on the steps I suggested for developing adverse events guidance and would suggest some essential practical steps for helping to ensure the duty of candour is successful. I would recommend that there is developed:

- A common language that is easy to understand and share

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<sup>3</sup>[http://www.spsso.org.uk/sites/spso/files/consultations-and-inquiries/2013/13\\_02\\_27%20response%20to%20HIS%20consultation%20%28both%20docs%29.pdf](http://www.spsso.org.uk/sites/spso/files/consultations-and-inquiries/2013/13_02_27%20response%20to%20HIS%20consultation%20%28both%20docs%29.pdf)

- A common understanding of when the duty should be implemented (also when it could be implemented even if not required) and the benefits it can bring. It is the latter point which is most likely to help staff. If staff have a full understanding of the benefits they are more likely to initiate this.
- Case studies and examples that clearly show the benefits of candour and the outcomes sought. Examples are often more powerful than, and can support, key definitions.
- Simple systems and definitions. There is often a direct relationship between simplicity and transparency. We also find that when a system is simpler, it is easier to focus on the substance, rather than the process.
- Involvement the family/patient/wider community. The comments and views of patients and family should be encouraged. This should extend not only to simply asking them about their experience but extend to actively involving them in helping to identify the causes and future improvement.
- Legislation that enables action and the creation of procedure rather than that which restricts action and creates procedures.
- Clarity about who is responsible for supporting organisations as well as monitoring and reviewing the guidance on an on-going basis. It may be useful to note that it is our experience this does not necessarily need to be done by the same organisation. We have largely provided the process and support for complaints handling while regulators have monitored, often using tools we have helped to create.

### **Risks of a legislative approach and ensuring fit with the wider landscape.**

While I have said above that a legislative approach has been helpful to us in supporting the improvements to complaints handling, we also have experience of legislation blocking improvements. In health and social care, three different legislative provisions make it impossible for organisations to provide a fully joined-up approach. We also need to recognise the limits of legislation. The Scottish Health Council recently reported on the first complaints reports produced by the NHS in terms of their legislative requirements and found a great deal of inconsistency. Work to help boards is now being taken forward.

In our experience the process, enabled by the legislation, of working with organisations to develop an approach proved very helpful in allowing us to interact with these organisations to help them see complaints differently. The on-going support put in place for improving complaints handling, including training has been critical. As already mentioned, it should be noted that, while the resources used have been limited, they do need to be sustained. This is not something that can be a one-off but which needs regular support.

The duty of candour will be only one duty in a broader landscape. As the consultation notes, systems of governance and reporting that are already in place or being developed can be adapted. Work is being undertaken to improve the way complaints are reported and it would make sense to report on this duty alongside reporting about complaints, patient opinion feedback, adverse events and other tools used to assess the experience of care. In closing, I would recommend that, as part of the work in developing this, a review be undertaken to ensure it complements the work on adverse event reviews and also on complaints and other methods by which patients can feedback such as patient opinion.