

Consultation on Proposals to Introduce a Statutory Duty of Candour for Health and Social Care Services

Scottish Care Response – January 2015

Introduction

1. Scottish Care welcomes this opportunity to contribute to the Scottish Government's consultation on Proposals to Introduce a Statutory Duty of Candour for Health and Social Care Services. Please find below some information about Scottish Care and its membership, together with our response to the specific questions as requested.
2. Scottish Care is the representative body for independent social care services in Scotland. This encompasses private and voluntary sector providers of care home, care at home and housing support services across the country. Scottish Care counts over 400 organisations as members, which totals over 830 individual services. Scottish Care is committed to supporting a quality orientated, independent sector that offers real choice and value for money. Our aim is to create an environment in which care providers can continue to deliver and develop the high quality care that communities require and deserve.
3. In relation to older people's care, this sector provides 83% of the care home places in Scotland and over 50% of home care hours. There are more older people in care homes any night of the week than in hospitals - as at 31st March 2014 there were 902 care homes for older people providing 38,441 beds to 33,187 residents any night of the year, with 88% of these residents located within the independent sector.

Scottish Care's Response to Questions Posed in the Consultation

1. **Do you agree that the arrangements that should be in place to support an organisational duty of candour should be outlined in legislation?**

Yes. Scottish Care and its membership are supportive of the proposals to introduce a statutory duty of candour in health and social care services. This seems to be a logical and natural progression towards promoting the positive organisational culture that all parties want to see embedded in care and support services in order to deliver better outcomes for individuals. Scottish Care has always emphasised that organisations who endorse and adopt a transparent, honest approach to care and support, including through complaints and disclosure procedures, deliver far better outcomes and tend to have fewer significant issues than those where individuals and staff feel unable to speak out, feel they aren't listened to or are not fully informed about their care and support. Therefore any measures which encourage organisations to adopt an open approach if they are not already doing so is very much welcomed.

However, Scottish Care believes there needs to be more clarity on how these proposals would fit with existing organisational and regulatory protocols and procedures for dealing with disclosures of harm. In order for the duty of candour to be applied appropriately and

its associated accountabilities to be understood by staff and organisations, there needs to be a clear definitions relating to the duty of candour itself, what events should be disclosed and who the 'relevant person' for disclosure is.

2. Do you agree that the organisational duty of candour encompass the requirement that adequate provision be in place to ensure that staff have the support, knowledge and skill required?

Yes. It is essential that appropriate supports are in place within an organisation in order for the duty of candour to be applied effectively and in order for staff to feel confident in disclosing instances of harm to colleagues, managers, individuals and families. If the correct provisions are not in place, there is a real risk that the duty of candour would have an adverse effect on organisational culture: instead of promoting transparency and honesty and therefore facilitating staff and organisations to recognise and disclose issues and mistakes at an early stage, a lack of support, knowledge and skill could inadvertently breed a culture of blame or excessive risk aversion in settings and circumstances which are already often complex, emotive and sensitive for all involved.

3. A) Do you agree with the requirement for organisations to publicly report on disclosures that have taken place?

Yes. However Scottish Care believes there needs to be clarity on who organisations would report to in the first instance, and what would be done with this information. At present, we are unclear whether this would be through the regulatory bodies, such as the Care Inspectorate, or through another mechanism. Efforts also need to be made to ensure minimum duplication with other reporting requirements. Additionally, there would need to be clear guidelines or a framework for how this information should be reported to ensure consistency and that the right information is captured. Careful consideration also needs to be given to issues of confidentiality when reporting, and any timing issues. For instance, if there is an ongoing situation relating to the investigation of alleged harm, either by the organisation or an external body, there would need to be clear parameters around when these should be publicly reported. Scottish Care's view is that the duty of candour should relate to incidences of harm which have been reported, investigated, and concluded by the relevant parties.

Whilst it is important for these reports to highlight any organisational issues relating to the harm of individuals that need to be addressed or monitored by external agencies, those bodies dealing with this information need to be appropriately knowledgeable about what the reports contain. Otherwise, there is a possibility that the information could be interpreted incorrectly, confidentiality could be breached or concluded events could be resurrected inappropriately.

Additionally, there is no indication that the reports would be an effective way of capturing whether individuals involved felt that the process of disclosure had been managed well or whether a positive outcome had been achieved as a result. Without a means of capturing

the impact of disclosures on individuals, there is a risk that organisations could be technically compliant with the duty of candour but implementing it in a completely inappropriate way.

Finally, Scottish Care would want to know what the implications or sanctions would be for organisations who do not report disclosable events in a satisfactory way. There needs to be clarity about who will police compliance.

B) Do you agree with the proposed requirements to ensure that people subject to harm are informed?

Yes. However as previously expressed there needs to be appropriate measures in place, particularly in terms of staff training and organisational support, to ensure that any disclosures are handled sensitively and compassionately.

The proposals require organisations to inform the ‘relevant person’ but this term needs to be defined clearly. In most cases and most importantly, this will be the individual themselves, but it could also include family members, friends, other colleagues or managers, regulators and other professionals depending on the circumstances. Appropriate ways of informing individuals with reduced capacity also needs careful consideration in terms of how these proposals will fit with existing legislation, policies and procedures.

C) Do you agree with the proposed requirements to ensure that people are appropriately supported?

Yes, there needs to be sufficient awareness-raising and support for individuals in relation to the duty of candour. This applies to both individuals within organisations who are involved in disclosable events and individuals who may have been harmed. In terms of staff, it is imperative that disclosures and their outcomes are managed constructively from the initial identification to their conclusion in order that the introduction of this duty has a positive impact on staff and the overall culture of organisations.

In relation to the individuals who have been subjected to harm, support is also crucial. Individuals who are cared for in health and social care settings are often vulnerable and therefore adopting a personalised approach to support would be critical. For these reasons, the definition of ‘appropriate support’ must encompass this. Advocacy must also be in place to ensure that individuals are empowered to recognise that a disclosable event may have taken place and to challenge the action or inaction of an organisation who they feel haven’t handled the event appropriately, which can be extremely difficult for individuals to have the confidence and support to do. At present, it is unclear who challenges would be made through: the organisation itself, a regulatory body or through legal process.

4. What do you think is an appropriate frequency for such reporting?

Scottish Care is of the view that annual reporting would be a logical and reasonable frequency for reporting. To require more frequent reporting than this could lead to an over-emphasis on paperwork for organisations, when the ambition is for organisations to become more outcomes-focused as opposed to process-driven. Less frequent reporting may lead to

less effective identification and monitoring of organisations who fail to successfully implement the duty of candour. One option for Registered Care Services would be to incorporate it into the Annual Return, currently supplied to the Care Inspectorate.

5. What staffing and resources that would be required to support effective arrangements for the disclosure of instances of harm?

Significant consideration needs to be given to the training needs of staff, in order that they are sufficiently upskilled to apply the duty of candour effectively in their practise. Staff have to feel confident in their responsibility and accountability in relation to disclosable events. Failure to provide the correct training, support and unambiguous information could lead to defensiveness and suspicion instead of the intended transparency and honesty. However, it must be recognised that organisations are often working within constrained budgets and staff capacity is often already extremely stretched, therefore the required staffing and resources to support effective disclosure arrangements must be recognised and built into wider planning and commissioning of health and social care services. This approach would be in the best interests of all involved in health and social care and would support compliance. The model of Training Trainers which accompanied the introduction of the Adult Support and Protection Act might be an appropriate model to use.

At the same time, it must be recognised that any training and resources can only be borne from shared, coproduced definitions relating to the duty of candour, disclosable events and what constitutes harm. There also needs to be a common, agreed understanding of who within an organisation has responsibility for disclosure – whether this is a range of staff and job roles or whether this is limited to senior figures within organisations.

6. A) Do you agree with the disclosable events that are proposed?

The proposed disclosable events appear to be logical and reasonable as an initial starting point. However, further work needs to be undertaken in order to reach a clearly defined set of events that are understood, applicable and agreed across all health and care settings. Scottish Care would argue that through these further conversations and consultation exercises, the preliminary disclosable events proposed here would need to be narrowed down and made more specific.

B) Will the disclosable events that are proposed be clearly applicable and identifiable in all care settings?

As Scottish Care's members cover a wide range of care settings but not all, we are unable to give a definitive answer. However, we again think that this would become clearer through further work on the definitions, particularly taking account of the fact that delivering health and social care, often including the circumstances surrounding illness, death and harm, constitute a complex set of conditions and contributing factors.

C) What definition should be used for 'disclosable events' in the context of children's social care?

No comment to make.

7. What are the main issues that need to be addressed to support effective mechanisms to determine if an instance of disclosable harm has occurred?

The main issues have already been outlined in Scottish Care's answers but in summary, they relate to the need to establish clear definitions of terms, understanding of staff accountabilities, appropriate training that is accessible to all organisations and an organisational infrastructure which provides ongoing support and guidance to staff. Service users in social care are already extensively covered by the reporting requirements stemming from both the Regulation of Care and Adult Support and Protection. As indicated, it would be important to build any new requirements into the existing systems and avoid unnecessary duplication or confusion.

8. How do you think the organisational duty of candour should be monitored?

It would seem logical for the regulatory bodies, such as the Care Inspectorate, to monitor the organisational duty of candour. However in order for these bodies to do so, there would need to be an introduction and articulation of applicable standards and clear outlining of consequences should an organisation fail to comply. For instance, would an organisation's Care Inspectorate gradings be affected if they were not applying the duty of candour in an appropriate way? It would be important that this only happened after an appropriate period of introduction.

9. What should the consequences be if it is discovered that a disclosable event has not been disclosed to the relevant person?

Failures to disclose an event may be extremely hard to identify, particularly if there is a negative organisational culture whereby staff do not feel able to own up to and address failings compounded by individuals within that service who feel unable to speak out or challenge, either through fear or a lack of capacity. Therefore careful consideration needs to be given to how to address this.

In situations where there is awareness of failures to disclose applicable events, this needs to be linked to who is monitoring the organisational duty of candour and what penalties are within their power to apply (see question 8).

In general terms, the minimum consequence should be a requirement for an organisation to detail how they will address the circumstances which led to a failure to disclose, and what steps they will take to mitigate the chances of this happening again.

However it should be noted that the circumstances surrounding a disclosable event, whether it is disclosed or not, are almost always complex and therefore any monitoring and consequences needs to be handled in a way which reflects this. The aim should be to encourage all organisations to feel confident disclosing information and reporting on these disclosures as a means of supporting improvement and positive relationships, not as an additional stick to beat organisations with unnecessarily.



The voice of the independent care sector in Scotland

Providers recognise that the establishment of a relationship based on trust and confidence between a service and their users and carers is hugely important and must be based on candour of communication from the outset. We believe this is actually best in a business as well as professional and moral sense.