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Proposals to introduce a statutory duty of candour for health and social care services: Consultation Analysis

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Between October 2014 and January 2015, the Scottish Government undertook a public consultation on proposals to introduce a statutory duty of candour to health and social care services. The duty would create a legal requirement for health and social care organisations in Scotland to inform people (and / or their families) when they have been accidentally harmed (physically or psychologically) as a result of the care or treatment they have received. The duty would relate to more serious events (those resulting in death, injury or prolonged harm) – referred to in the consultation as 'disclosable events'. The consultation received 109 responses. Key points from the analysis of the responses are summarised here.

Main Findings

- Respondents were largely supportive of the introduction of a statutory duty of candour: 80% agreed that legislation should be put in place to introduce such a duty in health and social care services.
- In addition, respondents were nearly unanimous (98% agreed) that the duty should include an organisational requirement to ensure that staff involved in disclosable events have the necessary support, knowledge and skills to respond confidently.
- Most respondents (93%) agreed with the proposed requirements for informing and offering support to individuals who are harmed accidentally as a result of care or treatment.
- Regarding the public reporting of disclosable events, 75% of respondents thought there should be a requirement for public reporting, and 62% favoured annual reporting.
- There was less agreement about the proposed definition of a disclosable event, and the examples of disclosable events given in the consultation paper. While 59% agreed with the events proposed, a quarter (26%) disagreed. This latter group included most of the local government respondents. Irrespective of whether they agreed or disagreed, respondents expressed concerns about the proposals, and thought that the definition of a 'disclosable event' was unclear.
- Consequently, 47% of respondents disagreed that the proposed disclosable events would be clearly applicable and identifiable in all care settings, while just 31% agreed. Those who thought the disclosable events *would* be clearly identifiable in all care settings usually qualified their support by saying, 'as long as they are clearly defined'.
- There was disagreement among respondents about the definition that should be used for disclosable events in the context of children's social care services. Some thought that the definition should be developed by professionals working in this field, while others thought the *same* definition should be used for disclosable events in adult and children's services.
- Respondents thought that successful implementation of the duty would require: clear definitions, training and guidance for staff, access to advisors, adequate resourcing, an organisational culture that supports transparency, and awareness-raising for patients and service users.

The Scottish Government
Riaghaltas na h-Alba

Background

Between October 2014 and January 2015, the Scottish Government undertook a consultation on proposals to introduce a statutory duty of candour for health and social care services.

The duty would create a legal requirement for health and social care organisations in Scotland to inform people (and / or their families) when they have been accidentally harmed (physically or psychologically) as a result of the care or treatment they have received. The duty would relate to more serious events (those resulting in death, injury or prolonged harm) – referred to in the consultation as 'disclosable events'.

The duty of candour would involve: a review of the contributory factors to the event; efforts to put matters right; and the requirement to apologise. It would also include a requirement to provide training and support to staff in implementing the duty, and to offer support to those affected by an incident of harm. Finally, it would require organisations to publish a report outlining how the duty had been implemented, including any improvements that have been identified and actioned.

The consultation contained nine questions seeking views on the proposed requirements on organisations, the definition of 'disclosable events', and monitoring arrangements.

Consultation respondents

The consultation received 109 responses – 7 from individuals and 102 from organisations. Organisational respondents included: NHS and local government organisations; third sector agencies; agencies responsible for the scrutiny and regulation of professional practice; and organisations that support, train or represent health and social care staff.

Main findings

Views on the introduction of a statutory duty of candour

Eighty percent (80%) of respondents agreed that arrangements should be put in place to introduce an organisational duty of candour for health and social care services. Twelve percent (12%) disagreed.

Respondents who agreed with the proposal thought that legislation could be a useful lever in bringing about greater openness and transparency in services, and in addressing perceived failings associated with current arrangements based on ethical and professional codes. A legislative approach would also ensure that the duty was implemented in a clear and consistent way.

Respondents who disagreed with the introduction of a statutory duty of candour were supportive of the policy aims behind the proposals but thought that openness with patients and service users would be better achieved through staff training, guidance and professional codes, rather than through legislation. This group also argued that a case had not been made for establishing a duty of candour in law, and that legislation would not address the issues of organisational culture which currently inhibit disclosure. In addition, there was a concern that the duty and its associated reporting requirements would result in a (potentially) costly and bureaucratic burden upon organisations, and would undermine the valuable learning opportunities which can result from identification of more minor events and 'near misses'.

Ensuring that staff have the required support, knowledge and skills

The consultation proposed that the statutory duty of candour should include an organisational requirement to ensure that staff involved in disclosable events have the necessary support, knowledge and skills to respond effectively and confidently. Views in relation to this question were nearly unanimous – with 98% of respondents saying that they agreed with the proposal.

Informing and supporting people who have been harmed

The consultation set out proposed requirements for ensuring that people harmed as a result of an adverse event are informed, and for offering 'reasonable support' to the individual, their relatives and to staff involved.

Ninety-three percent (93%) agreed with the requirements for informing people who are harmed. The requirement to inform was seen to be consistent with an open and honest approach to care and treatment. However, respondents also argued for a degree of flexibility, and commented that there could be exceptional cases where the disclosure of harm itself could be a source of further harm, and may not be in the best interests of the person affected. Respondents wanted clarity about a range of issues related to how to fulfil this requirement in practice.

Those who disagreed with the requirements for informing people who had been harmed were concerned about the resource implications, and whether it might result in undermining public confidence in services.

In relation to the proposal to offer support to people, again, most respondents (93%) agreed, and there was a general view that support should not only be offered but that its uptake should be encouraged. Respondents suggested that the provision of support would assist with communication; help people to understand the situation and participate in the process; and reduce the risk of the disclosure itself causing further harm. However, there were concerns about the resource implications of the requirement and how it would apply to small community-based services.

These concerns were echoed by those who did not agree with the requirement to provide support. This group also thought that such a requirement would not add value to existing professional duties or good practice, and would be open to local interpretation.

Public reporting

The consultation sought views on the public reporting of disclosures which have taken place. Three-quarters of respondents (75%) thought that organisations should be required to publically report on disclosures, while 13% disagreed. Whether or not respondents agreed or disagreed, they called for clarity about the *purpose* of public reporting, and the *nature* of any reporting (e.g. in relation to the intended audience, or the form and level of detail).

Those who agreed with the requirement for public reporting generally saw it as being in line with openness and accountability in public services. There was a view that to *not* have such a requirement would be 'at odds with a duty of candour'. However, respondents also had concerns about: the need to protect the rights and privacy of those involved; how the information might be misinterpreted or misused; and the possible costs associated with public reporting.

Those who disagreed with the requirement for public reporting echoed these concerns and thought that public reporting would provide no additional benefit – either to those who had been harmed, or to organisational learning.

In terms of the frequency of public reporting, the majority of respondents (62% of those who commented) favoured annual (rather than more frequent) reporting, as this was seen to be 'manageable' and 'proportionate'.

Staffing and other resources

Respondents were asked for their views on the staffing and resources required to support effective implementation of the duty of candour. In relation to staffing, respondents expected that a wide range of staff would need to contribute to meeting the obligations of the duty and that this would have significant costs. They also identified needs in relation to: staff training; the resourcing of initial set-up activities (i.e. developing policies, procedures, etc.); the provision of support services for staff and for people affected by a disclosable event; and ongoing administrative support. Respondents again raised concerns about the resource implications of the duty.

Disclosable events

The consultation paper set out a definition for 'disclosable events' and provided a list of events as examples. Respondents were asked if they agreed with the events proposed, and whether the events would be clearly applicable and identifiable in all care settings.

A majority of respondents (59%) agreed with the disclosable events proposed. However, over a quarter (26%), including most of the local government organisations, disagreed. Those who disagreed had a range of concerns about the disclosable events proposed, and these *same* concerns were also raised by those who agreed. The main point made by both groups was that the definition of a 'disclosable event' was unclear.

Respondents also queried, or disagreed with, the examples of disclosable events given in the consultation document. Some went on to describe scenarios in which such events would *not* be considered to be adverse but, rather, would be reasonable and appropriate responses in a clinical context.

In relation to the question about whether the disclosable events would be clearly applicable and identifiable in all care settings, nearly half of respondents (47%) said 'no', while a third (31%) said 'yes'. Respondents suggested that it would be difficult to define a set of disclosable events that would be applicable across all branches of medicine, and in both health and social care services.

Those who thought the disclosable events *would* be clearly identifiable in all care settings generally qualified their support by saying, 'as long as they are clearly defined'. Those who disagreed thought that the proposed events were too focused on acute healthcare services. This group reiterated their views that the proposed definition lacked clarity, and suggested that not all of the proposed events would result in harm.

Disclosable events in children's social care services

The consultation asked for views on the definition that should be used for 'disclosable events' in the context of children's social care services. There was disagreement among respondents about this issue. Some thought that any such definition should be developed by professionals and other experts who work in this area, while others argued that the *same* definition should be used for 'disclosable events' in adult and children's services.

Respondents also thought that any definition or guidance about disclosable events for children's social care services should take into account and be consistent with the wider legislative and policy context in this area.

Supporting mechanisms to determine if disclosable harm has occurred

The consultation document asked respondents their views about how to support effective mechanisms to determine if an instance of disclosable harm has occurred.

Respondents identified the need for: a clear definition for disclosable events; training and guidance for staff; access to advisors (both internal and external to organisations);

organisational policies and procedures to support the identification of disclosable events; adequate resourcing; an organisational culture that supports transparency and openness; and awareness-raising among patients, service users and their carers.

Monitoring the statutory duty of candour

Respondents were asked their views about how the organisational duty of candour should be monitored, and what the consequences should be when it is discovered that a disclosable event had not been disclosed. The consultation paper also described how the existing roles of the Scottish Government, Healthcare Improvement Scotland and the Care Inspectorate would relate to monitoring the implementation of the duty of candour.

Respondents generally agreed that monitoring should take place through existing systems. Respondents were concerned that if a *new* monitoring system was set up, it would cause duplication and confusion. However, there were concerns that Healthcare Improvement Scotland and the Care Inspectorate have slightly different functions, and this could result in inconsistency in the way the duty of candour is monitored in health and social care services.

Respondents thought that consequences for not disclosing a disclosable event should be in line with existing procedures and processes, with staff subject to existing disciplinary or regulatory proceedings and organisations being required to put improvement plans in place. Others thought that the consequences should depend entirely on the circumstances.

Cross-cutting issues

Across all questions, several recurring themes were evident in the comments of those agreeing with the proposals and those disagreeing. These included: support for a culture of openness in health and social care services; the importance of taking account of the needs of different groups in disclosing incidents of harm; and calls for clarity in relation to certain proposals (particularly the definition of a 'disclosable event'). There was also a view that, as much as possible, existing procedures and systems should be used for identifying and reporting events.

This document, along with full research report of the project, and further information about social and policy research commissioned and published on behalf of the Scottish Government, can be viewed on the Internet at: http://www.gov.scot.uk/socialresearch. If you have any further queries about social research, please contact us at socialresearch@scotland.gsi.gov.uk or on 0131-244 2111.

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