# Health and Social Care Alliance Scotland

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


## 14 January 2015

The Health and Social Care Alliance Scotland (the ALLIANCE) is the national third sector intermediary for a range of health and social care organisations. It brings together over 800 members, including a large network of national and local third sector organisations, associates in the statutory and private sectors and individuals.

The ALLIANCE's vision is for a Scotland where people of all ages who are disabled or living with long term conditions, and unpaid carers, have a strong voice and enjoy their right to live well, as equal and active citizens, free from discrimination, with support and services that put them at the centre.

### Consultation Questions

**Question 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. The ALLIANCE strongly welcomes the proposed statutory duty on organisations in this regard which would be an important step forward in supporting the open, transparent culture which is central to the delivery of safe, effective care and learning and improvement in health and social care services.

A culture of openness will not be achieved by legislation alone, however, and must form part of the wider commitment to person centeredness, co-production and asset-based approaches embedded within the 2020 Vision for Health and Social Care[1]. People who use support and services and carers should be empowered and informed to play an active role in all elements of their care and treatment through quality communication with health and social care staff.

[1] http://www.scotland.gov.uk/Resource/0042/00423188.pdf

As such, the ALLIANCE supports the Dalton – Williams review's[2] recommendation that the duty of candour "must also be a duty to disclose information in cases where a patient or carer believes that harm has been done." Responding candidly to any request for information about potential harm offers the valuable opportunity for facts to be established, lessons to be learned and where necessary, for trust to be restored.

**Question 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. Implementing the duty of candour successfully will require quality training, support and resources for staff. It is therefore appropriate that organisations are under a duty to ensure that this is adequately provided.

**Question 3a: Do you agree with the requirement for organisations to publically report on disclosures that have taken place?**

The ALLIANCE supports the proposals for public reporting as a means of supporting learning and service improvement following disclosable events.

We would, however welcome further clarification on the format(s) in which disclosures would be reported and how people who use support and services and the general public would be able to access this information. The public reporting process should be designed to ensure that the confidentiality of all parties involved in the disclosable event is respected.

**Question 3b: Do you agree with the proposed requirements to ensure that people harmed are informed?**

Yes. It is critically important that people using health and social care services who are subject to an adverse event resulting in harm are informed of this in a sensitive and professional manner, and the proposed requirements to support this as outlined in sections 6.1 to 6.8 of the consultation document appear to be both appropriate and clear.

[2] https://www.rcseng.ac.uk/policy/documents/CandourreviewFinal.pdf

**Question 3c: Do you agree with the proposed requirements to ensure that people are appropriately supported?**

It is important to recognise that people who have been subject to an adverse event resulting in harm and their families / carers will in many cases be affected emotionally or psychologically as a result, and therefore require to be supported through the disclosure process. The ALLIANCE welcome the proposed requirement that "there must be an offer of reasonable support provided to the person harmed, relatives and staff who have been involved with the event", however we would expect accompanying guidance to provide further clarity about what the term "reasonable support" would include in this context.

**Question 4: What do you think is an appropriate frequency for such reporting?**
**Quarterly ☒ Bi-Annually ☐ Annually ☐ Other (outline below)**

**Question 5: What staffing and resources that [sic] would be required to support effective arrangements for the disclose of instances of harm [sic]?**

Training, resources and support for staff will be required to develop a shared understanding of the procedures to be followed and support the implementation of these steps in practice in a consistent and effective manner.

The consultation document states that all organisations will be responsible for ensuring that "all staff who are asked to be involved with disclosure have access to the relevant training, supervision and support". It is unclear whether this would refer to the creation of new, specific roles to support disclosure or whether staff will assume this (and receive the accompanying training) in addition to their existing roles.

**Question 6a: Do you agree with the disclosable events that are proposed?**

Yes. The ALLIANCE welcomes the breadth of the proposed definition.

**Question 6b: Will the disclosable events that are proposed be clearly applicable and identifiable in all care settings?**

It is likely that ascribing the primary catalyst and therefore responsibility for disclosable events may prove challenging in some circumstances. For example, due to the complexity and interrelated nature of interventions both within and across services, the end result of physical or psychological harm may be the cumulative product of a number of actions / inactions across a range of actors. In such circumstances, collaborative partnership working between organisations will be

crucial to make sure that people who use support and services are not placed at a disadvantage simply because their care pathway involves more than one provider.

**Question 6c: What definition should be used for 'disclosable events' in the context of children's social care?**

Social care services should have a Duty of Candour to children, and their families, when an action has been taken, or an action has not been taken, which results in that child being put at harm or a disadvantage since the point of first engagement with that service. As the social care service's duty of care begins when a child first becomes known to that service, the Duty of Candour should take effect from that point. The consequence of any action or inaction taken after the initial contact that has a negative impact on a child's wellbeing, or that of their families, should be disclosed under such a duty.

Any disclosure to a child, and their family, must be communicated in a way that is understandable and meaningful to them. This principle should not be undermined or denied in circumstances that the child concerned is presented by barriers to his/her communication with others. Additional efforts must be made in such circumstances to ensure that all children receive relevant information pertaining to events affecting them. Should the barriers to communicating such information be insurmountable, then a record should be made to ensure that future intervening services do not repeat damaging events.

Upon recognising that an event has occurred that puts a child, and their family, at harm or a disadvantage, social care services should be under a duty to disclose the relevant information within the appropriate fora according to the Getting It Right For Every Child's 'team around the child' approach. This information should therefore be shared with relevant agencies (including health and education) in the event that the child concerned has or is in the process of receiving a Child's Plan in order to ensure there is a collective effort to preventing such an event taking place again.

There should however be that caveat that on disclosing information to the child, and their family, an event has occurred that put them at harm or disadvantage, it should be considered whether the consequences will further risk the child's safety. The child's opinion on whether the information should be disclosed to their parents/guardians should be a consideration when deciding on implementing a duty of candour.

**Question 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?**

Again, quality training, support and resources for staff will be crucial in developing a shared understanding of the definition of an instance of disclosable harm and how such incidents can be identified in practice.

The consultation document states that "*organisations would require to demonstrate through their reporting that they have arrangements in place to consider events in relation to the agreed definition of physical or psychological harm, and that when they have determined harm has not occurred the decision-making process that has informed this decision.*"

These quality assurance arrangements may be strengthened by some level of external verification, with reviews of a selection of 'borderline' cases on to ensure that agreed definitions are being interpreted correctly and consistently.

**Question 8: How you think the organisational duty of candour should be monitored?**

It would be appropriate for the duty of candour to be monitored by the existing regulatory bodies (Healthcare Improvement Scotland and the Care Inspectorate) for the services that they have inspection and regulatory responsibility for.

Building on the increasing levels of joint inspection activity between Healthcare Improvement Scotland and the Care Inspectorate, collaborative partnership working between the two organisations in this area would be of value in developing a consistent and effective approach to the monitoring of the duty of candour across different care settings, and supporting learning and service improvement from the disclosures at a national level.

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

The consultation document highlights that the addition of the duty of candour as part of the inspection and monitoring system in England has been accompanied by a range of new enforcement powers, including civil penalties and criminal proceedings for repeated failures. The Scottish Government should consider giving regulatory bodies in Scotland similar powers as mechanisms to tackle non-compliance.

Candour cannot merely be a matter of compliance however, and needs to be part of a broader commitment to safety, person centeredness and service improvement.

**For More Information**

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**About the ALLIANCE**

The ALLIANCE has three core aims; we seek to:

- Ensure people are at the centre, that their voices, expertise and rights drive policy and sit at the heart of design, delivery and improvement of support and services.

- Support transformational change, towards approaches that work with individual and community assets, helping people to stay well, supporting human rights, self management, co-production and independent living.

- Champion and support the third sector as a vital strategic and delivery partner and foster better cross-sector understanding and partnership.