# CONSULTATION RESPONSE

*9 January 2015*

Dear Sir/Madam,

**Health Foundation response to the Scottish Government consultations on proposals to introduce a duty of candour and an offence of wilful neglect or ill-treatment**

1. Thank you for the opportunity to respond to these proposals on two major policy initiatives, which are an attempt to drive improvements in the quality and safety of care in Scotland. The Health Foundation has undertaken and funded a number of projects in the areas of patient safety, increasing transparency and improving safety culture, and it is from this perspective that we respond. We have combined our responses to both of these consultations into a single document for expediency, and we have not responded to each and every question. We hope you find our comments helpful.

**About the Health Foundation**

2. The Health Foundation is an independent charity working to improve the quality of healthcare in the UK. We are here to support people working in healthcare practice and policy to make lasting improvements to health services. We carry out research and in-depth policy analysis, fund improvement programmes in the NHS, support and develop leaders and share evidence to encourage wider change.

**Our overall view**

3. Being open with patients when something goes wrong with their care is clearly the right thing to do. Similarly, when there is evidence to demonstrate that any failing was due to the wilful neglect or deliberate ill-treatment of a patient, it is important for the State to send a message that this is unacceptable. **We therefore support the proposals both to introduce a statutory duty of candour and an offence of wilful neglect or ill-treatment in health and social care settings. However, this comes with the caveat that both actions are a necessary but insufficient step towards creating a culture in the NHS which would effectively make both pieces of legislation redundant.** We make some specific comments on both proposals below, along with other suggestions of how this ambition could be achieved.

**Proposals to introduce a statutory duty of candour**

4. There is a persuasive evidence base to support openness when something goes wrong

with an individual's care, much of which is referenced in the consultation document[1] and also in the briefing document which accompanied the threshold review led by Professor Norman Williams and Sir David Dalton.[2] The debate quite rightly has shifted to how the policy can best be implemented to achieve the desired effect – increasing openness between the providers and recipients of health care – and minimising any unintended consequences.

5. We welcome the move to complement existing mechanisms for disclosure (section 2.7 of the consultation document). Proportionality is a principle of good regulation, therefore any new statutory duty should minimise additional burdens on the NHS and the risk of duplication. We also welcome the emphasis on providing training and support for staff involved with disclosure, as well as people who have been affected by an instance of harm (section 2.5).

*6.* Our understanding of harm in health care has evolved, even in recent years, which makes it even more important to have clear definitions of what constitutes a 'disclosable event'. We were unclear as to exactly what was being proposed in the document. In points 9.9 to 9.12, the document sets out some 'issues' that ought to be taken into account. We note that these have been taken from the definitions of moderate and severe harm in the Appendix to *Being Open*.[3] We consider these to be sensible and well used categories of harm. Whichever definitions are chosen, they should be used consistently, including in any supporting guidance, and accompanied by examples to illustrate them.

7. To support professionals in implementing the proposed legislation, we would also suggest that any guidance includes reference to the typology of patient harm developed by Charles Vincent and colleagues in their report *The Measurement and Monitoring of Safety*.[4] This typology illustrates the many ways in which people can be harmed as a result of the care they receive (or don't receive):

    - treatment-specific harm eg. adverse drug reactions
    - harm due to over-treatment eg overuse of antibiotics leading to Clostridium difficile
    - general harm from healthcare eg falls
    - harm due to failure to provide appropriate treatment eg failure to provide rapid and effective treatment for myocardial infarction
    - harm resulting from delayed or inadequate diagnosis eg misdiagnosis of cancer by primary care doctor
    - psychological harm and feeling unsafe eg clinical depression following mastectomy.

8. In terms of the language used in the legislation and/or any supporting guidance, we

[1] Scottish Government, 2014. *Consultation on Proposals to Introduce a Statutory Duty of Candour for Health and Social Care* Services. Available at: http://www.scotland.gov.uk/Publications/2014/10/9897/downloads
[2] *Briefing for the Duty of Candour Threshold Review Group: Review of definitions*. Available at: http://www.rcseng.ac.uk/policy/documents/duty-of-candour-review-of-definitions
[3] National Patient Safety Agency, 2009. *Being Open*. Available at: http://www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726
[4] Health Foundation, 2013. *The measurement and monitoring of safety*. http://www.health.org.uk/publications/the-measurement-and-monitoring-of-safety/

consider that the wording in section 1.1 is clearer, and would therefore be more effective, than that used in section 3.1:

| **Section 1.1** | **Section 3.1** |
|---|---|
| *...require organisations providing health and social care in Scotland to tell people if there has been an event involving them where the organisation has recognised that there has been physical or psychological harm as a result of their care or treatment* | *...a statutory requirement on organisations providing health and social care to have effective arrangements in place to demonstrate their commitment to disclose instances of physical or psychological harm* |

9. The consultation document is right to point out the known barriers to disclosure (section 2.9). It should be acknowledged, however, that the tools at the disposal of Government are largely ineffective in tackling these kinds of cultural or human factors. As we pointed out in our response to the Dalton/Williams Review:[5]

> *It is therefore important to see the introduction of any duty of candour as part of a much wider, and more ambitious, suite of activities to improve openness in the NHS...These activities should include a greater emphasis on seeking genuinely informed consent such that patients are fully aware of the risks of intervention – this will help to create a more proactive approach to safety management across the NHS. It must also include further work to create the right safety culture within organisations, where people feel able to surface safety issues with their colleagues.*

10. The Health Foundation has undertaken work on seeking genuinely informed consent, creating a proactive approach to safety and fostering a positive safety culture in health care organisations. We would be delighted to share this work with you in more detail if that would be helpful.

**Proposals to introduce an offence of wilful neglect or ill-treatment**

11. It seems sensible to propose legislation that extends the scope of existing offences, that currently apply only to mental health patients and adults with incapacity (Section 5 of the consultation document). We also agree with the proposal to cover both health and social care. We also agree with the decision to exclude unpaid carers providing care in a person's home, as this would not appear to be a proportionate solution to the problem identified.

12. The proposed approach will focus on the *conduct* of the offender not the *outcome* for the patient. Although this takes a different approach to that proposed for the Duty of Candour, we consider it to be appropriate given that the two areas of new legislation are tackling different problems. The Duty of Candour seeks to improve openness with patients, while this legislation seeks appropriate punishment for wilful acts of negligence. We suggest that this distinction is made clear to people.

13. We note that no estimate was given of the potential number of additional cases that might

[5] Available on request

be generated, due to a lack of evidence. The corresponding consultation for the introduction of the offence in England suggested that there may be up to 240 prosecutions per year. Although this is an estimate derived for a different context, this would be a significant number of prosecutions which could further damage the reputation of the health service, and the trust of the professionals working within it. We suggested in our response to the England consultation that more work is done to ensure that the risk of professionals becoming too risk averse, and the effect this might have on a culture of openness, is mitigated.[6]

For further information:

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[6] Health Foundation response to consultation in England on wilful neglect or ill-treatment. Available at: http://www.health.org.uk/areas-of-work/influencing-policy/consultation-responses/health-foundation-response-to-wilful-neglect-or-ill-treatment-in-health-and-social-care/