

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

## BMA SCOTLAND RESPONSE

### Background

The British Medical Association is a registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of around 140,000 representing 70% of all practising doctors in the UK. In Scotland, the BMA represents around 16,000 doctors.

BMA Scotland welcomes the opportunity to comment on the Scottish Government's proposals to introduce a statutory duty of candour for organisations providing health and social care services. BMA Scotland believes that just as all NHS staff must be honest and transparent in everything that they do in order to best serve and protect their patients, the organisations they work in should equally always be open and honest with patients about their care. As such, an organisational duty of candour could potentially improve the current organisational culture, and complement the existing regulation for individual doctors. However, we have significant concerns around the potential administrative burden and additional costs on NHS bodies of introducing any additional responsibilities at a time of increasing pressure on the NHS. Any additional workload would need to be fully resourced, particularly training and ongoing support for NHS staff, and any new procedures implemented in such a way as to avoid introducing any unnecessary bureaucracy that might divert scarce resources away from frontline patient care.

Particular consideration should be given to the impact of this proposed duty on individual GP practices where the additional workload and requirements set out in a statutory duty of candour could create significant levels of unfunded work which would divert GPs and their staff away from their core clinical activities.

We believe that this new duty of candour should be an over-arching principle underpinned by a description of how existing processes, responsibilities and mechanisms (where they already work well) will fulfill it, and more detail on how any gaps should be filled.

Any incident/near miss which occurs should be seen as an opportunity for improvement and learning - any new approach to a duty of candour should make this a very clear goal and should demonstrate how this is going to be achieved. We would note that the timing of this discussion is unhelpful alongside the almost simultaneous Scottish Government consultation on wilful neglect as the two could be seen, wrongly, as being related, and have a negative impact upon each other.

Within the medical profession, doctors are expected to be open and honest with patients when things go wrong. Doctors are strictly regulated under the Medical Act 1983 by the General Medical Council which is an independent, accountable regulator and has a duty to ensure proper standards in the practice of medicine<sup>1</sup>. The General Medical Council's Good Medical Practice Guidance<sup>2</sup> states:

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<sup>1</sup> Guidance to the GMC's Fitness to Practice Rules, 2004, [http://www.gmcuk.org/Guidance to the FtP Rules 2 .pdf 35398575.pdf](http://www.gmcuk.org/Guidance%20to%20the%20FtP%20Rules%202.pdf)

<sup>2</sup> Good Medical Practice, GMC [www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp)

*“30. If a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects.*

*“31. Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response including an explanation and, if appropriate, an apology. You must not allow a patient’s complaint to affect adversely the care or treatment you provide or arrange.”*

Good Medical Practice clearly sets out the principles and values on which good practice is founded and these principles together describe medical professionalism in action. The guidance is addressed to doctors, but it is also intended to let the public know what they can expect from doctors. If doctors do not adhere to the principles outlined in Good Medical Practice, their registration can be called into question.

Of the eight UK wide professional regulatory bodies, only the General Medical Council (GMC) and Nursing and Midwifery Council’s (NMC) standards explicitly require their registrants to be candid with people harmed by their practice. As a result the GMC is currently working with the NMC to consult on guidance on candour to apply across these fields. We would be interested to see how this guidance would interact with a statutory duty of candour in Scotland.

A duty of candour may be a mechanism to ensure that organisations are clear about their obligations to report incidents and have effective arrangements in place to do so. However legislation to make this a statutory duty is not necessarily the most effective means to create and develop a transparent and open culture, especially since there would be no sanctions, either criminal or civil, for non-compliance. There needs to be an overarching culture of quality, a focus on patient safety which is underpinned by a shared set of value. It is vital that doctors and all workers feel they can speak up for patient safety without risking hostility from colleagues, management or the media. There have been high-profile cases of doctors who have been ignored, silenced or even punished by their employers after raising safety issues. In order to address an underlying culture that may discourage people from speaking up, employers should have a duty to listen to staff when they do report concerns, and to protect them if necessary. Staff should be encouraged and recognised for following their professional guidelines, and more training may be necessary to help people communicate more effectively when, for example, treatment has not gone as well as expected or an error has occurred in the process of their care. More effective policies addressing bullying are also necessary.

We would note that the consultation is very heavily focused on healthcare and existing disclosure arrangements and research, and has considerably less detail on social care services. Attached below is our response to the specific questions in the consultation and we look forward to continuing to contribute to this process.

**Question 1: Do you agree that the arrangements that should be in place to support an organisational duty of candour should be specified in detail**

If an organisational duty of candour is introduced we would agree that the arrangements to support it should be specified in detail. There needs to be a planned, co-ordinated and

consistent approach to support an organisational duty of candour together with ensuring that the public are appropriately informed about the role and outcome of this duty.

A new duty of candour must be aligned with existing disclosure arrangements. There are already arrangements in place in general practice to submit information regarding all complaints and significant events. Extending this would need considerable support and appropriate resourcing, and should not increase bureaucracy in an already overburdened and overstretched health service.

**Question 2: Should 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?**

Training and support should be available for staff involved with disclosure to ensure that they have the support, knowledge and skill that they require. This would place an additional burden in particular on general practice as being both self-employed and an employer, and would require significant additional resourcing.

Communication skills and 'breaking bad news' is part of every medical student's training and is further expanded on in specialist training. There would therefore be a potential risk that introducing mandatory training which is not sufficiently flexible to individual needs and experience may take time unnecessarily away from patient care. Good Medical Practice makes the existing duty clear:

*"24. Doctors and students must build relationships with patients based on openness, trust and good communication. Relatives, carers, partners and anyone else close to the patient, should also be treated with consideration and be given support when needed."*

We support the consultation's recognition that existing programmes developed to improve the preparation of doctors to make such disclosures are relevant and applicable to other care professionals.

As part of this support, in order to develop and encourage a culture of raising concerns and reporting near misses as well as incidents, the emphasis within organisations should be on improvement and working together to improve patient outcomes rather than developing a blame culture. Unfortunately, in parts of the NHS, a blame culture may persist where staff are afraid to speak up and incidents therefore go unreported. This increases risk to patients and creates difficult working conditions for staff. The BMA has guidance for doctors on how to raise concerns which is accessible on our website: <http://bma.org.uk/practical-support-at-work/whistleblowing>

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

Public reporting is already a requirement within the GP contract. In terms of para 6.7 that "the organisation must provide an apology and must confirm all of the actions taken in a written record. The contents of this will inform the regular public reports of disclosable events and organisational response to these". We support the role of a meaningful apology which can help repair a damaged relationship and restore dignity and trust, thought needs to be given

about how to handle this appropriately when there is a dispute over where fault lies. When things go wrong doctors apologise at the earliest opportunity as this is a key professional duty. Research shows that most poor outcomes are due to system rather than individual failures. Apologies should be couched in these terms if this is to be a process that is truthful and appropriate. The GMC is separately consulting on whether its hearing panels, run by the Medical Practitioners Tribunal Service, should be able to demand that doctors apologise where patients have been harmed if the doctor hasn't already done so, and again we are interested on how that would intersect with this.

For both 3a and 3b, there should be appropriate communication with service providers who are involved to ensure they are informed and supported throughout the process.

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

Organisations should inform people who are harmed. The requirements may not go far enough, as it is not always certain immediately whether harm has followed an adverse event. The severity of some incidents ultimately resulting in permanent harm may not be apparent at the outset and only become apparent weeks or months later. If this is the case, under this duty the event should be disclosed.

There is a potential risk that the introduction of a duty of candour may lead to an increase in the number of patients seeking legal redress - there is historically an issue of underclaiming in Scotland for medical negligence,<sup>3</sup> and a statutory duty of candour may lead to a rise in claims. There would need to be clear and well developed guidance on the role and function of this duty, and a careful introduction and public education campaign.

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

We agree that people should be appropriately supported, provided there is recognition that each person has different needs and individual circumstances will vary. There should be reasonable support offered to the person harmed, relatives and staff involved with the event, but also with sufficient room for flexibility.

**Question 4: What do you think is an appropriate frequency for reporting?**

It is important to strike the balance between responsible reporting and over bureaucratisation burdening an already stretched health service. Small organisations should not be required to report more frequently than annually. We agree with the statement in para 7.7 that many organisations will have local procedures in place for reporting, disclosure and support. Introducing the duty of candour should not negatively impact on these local procedures where it is working well.

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

IT resources need to be in place to support reporting of instances across health (primary and secondary) and social care, with an emphasis on confidentiality requirements. Instances of

<sup>3</sup> <http://www.scotland.gov.uk/Resource/0039/00394482.pdf>

harm may cross health and social care boundaries and therefore funding to allow everyone to attend reviews. More robust systems should be in place. There needs to be integrated centralised reporting system, and there could therefore be difficulties in primary care being engaged in a national process which is not carried out through easily accessible IT systems. Reporting needs to be made as simple as possible, to encourage staff to report all events including “avoided events”. A reporting system that is straightforward to use will ensure that sufficient information is fed in to allow monitoring of weaknesses, “one-off” incidents and emerging patterns.

As noted above, there should be appropriate communication with service providers who are involved to ensure they are informed and supported throughout the process. At present we are aware from our members that sometime those who report an adverse event through Datix can feel unsupported and there are concerns that there is no follow up to being told what has been done to prevent similar problems from reoccurring. The current system should be improved so that staff feel their opinions and input are valued, which would encourage them to engage further in a system intended to improve the care of patients.

In general practice, appropriate resourcing for staff training and implementation needs to be identified and agreed prior to the introduction of a statutory organisational duty of candour.

<b>Question 6a: Do you agree with the disclosable events that are proposed?</b>
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We agree that disclosable events (i.e. major harm to patients) should be included. It would be helpful if the two categories were more relevant to clinical care and less on financial loss or adverse publicity (in healthcare, the National Framework for Adverse Events outlined episodes of harm). In terms of the definitions defined in the Risk Assessment Matrix for NHSScotland we agree that it would not be appropriate to include an event simply because it has attracted national media coverage as this would not necessarily reflect that there has been an issue of physical or psychological harm. While we recognise the benefits of the approach outlined in paragraph 9.6, “that each instance must be considered on its individual merits, taking account of the specific clinical and care elements of individual care episodes”, this would require constant consideration of whether ‘harm’ has occurred on a case by case basis and would have a significant impact on workload for those involved.

The proposals as set out do not make it entirely clear where the boundaries are between where harm has occurred (an adverse event) and the disclosure of an episode. It would seem that some minor adverse events or incidents such as an unexpected (mild-moderate) side effect from a medication (common in general practice) are excluded by the two categories of harm: death and prolonged treatment/intervention. We would welcome confirmation that the organisational duty of candour is only dealing with critical adverse events. If it is extended beyond this, it could be especially difficult for GP practices, especially smaller practices and single handers where the bureaucratic burden of this new process would be significant.

The national approach should include all care provided throughout NHSScotland and we would welcome a consistent approach while acknowledging a degree of flexibility. Each event needs to be considered on its individual circumstances, taking account of specific clinical and care elements. While all major incidents of harm should be subject to a duty of candour, this statutory obligation may risk diverting attention from incidents of near misses – if these are dealt with appropriately and a culture of sharing encouraged, they can provide an invaluable

source of learning and development for organisations. Patient safety can be protected if we have the ability to learn from mistakes in an open and blame-free environment.

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

No. It is difficult to define and will vary across each setting and area. For example care homes may ask GPs to attend for all falls when no injury is evident; this may evoke a report to the Care Inspectorate.

These proposals should be clearly applicable and identifiable to employees as well as service users in all care settings. This is not explicitly stated. For example, undermining of an employee results in psychological harm, perhaps also in physical damage to health. It is important that the duty of candour applies in this situation also so as to protect employees as well as health care and social service users from harm. Proposals in the consultation should be made clearer in regard to this.

If a duty of candour is introduced then clear guidance will be needed for general practice and in particular for single-handed practitioners, where the responsibility falls on an individual rather than an organisation.

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

We are not in a position to comment on definitions for 'disclosable events' in the context of children's social care. The threshold chosen for social care should however be broadly consistent with that used within the NHS.

**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?**

See our response to question 5 above. Improved reporting procedures would go some way to being able to define whether an instance of disclosable harm has occurred. There needs to be a culture developed within health and social care organisations of openness, transparency and trust. We would wish to see clear guidance in place for service users and professionals on how the new duty would work in practice, setting out expectations very clearly and with worked examples.

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

It should be monitored by appropriate professional bodies who are both independent and also have the confidence of patients, professionals and management. We would welcome the opportunity to be part of future discussions on how a new statutory duty should be monitored to ensure consistency.

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

There are no sanctions, either criminal or civil, for failure to comply with the new proposed duty. Making more law is not in itself a form of action. Where there is clear evidence that the

organisation's duty of candour has not been complied with, there should be an investigation, and, if appropriate, an action plan to address the reasons for the organisational failure to comply.

**BMA Scotland**  
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