

Duty Of Candour – The Background

Disclosure of harm is when a person has been injured as a result of their care or treatment. Improvements in the process to support these incidents being revealed is an important part of making a safer environment for everyone involved. There are several healthcare organisations worldwide that have introduced arrangements to support these incidents being revealed. The Berwick Report highlighted the importance of the need for patients or carers affected by serious incidents to be informed and supported.

It is internationally recognised that between 10-25% of occurrences of healthcare (in general hospital, community hospital and general practice) are associated with a harmful event. However, it has also been recognised that as few as 30 per cent of incidents resulting in harm are disclosed or revealed to people who have been affected. When mistakes are denied or dismissed this can often lead to distress and people spending several years seeking the truth, accountability and an apology.

Visits to all the NHS Boards in Scotland confirmed that the level of support across the country varies when incidents result in harm. The Scottish Government wants to introduce an organisational duty of candour in Scotland. This will mean that services will need to make sure that they are open and honest with people when something has gone wrong with their care and treatment.

Objective

The Scottish Government intends to introduce a statutory or legal requirement for organisations, providing health and social care, to have arrangements in place that work to show their commitment to reveal instances of physical or psychological harm and to support continuous improvements in quality and safety across Scotland's health and care services.

Ethically, morally and professionally health and care professionals are already required to tell people about incidents resulting in harm. The clear requirement for candour or honesty in professional standards and codes of conduct correspond to the proposed introduction of a duty on organisations.

Rationale for Government intervention

Ethical and policy guidance has largely failed on its own to improve rates of disclosure or revelation. There has been strong support for the benefits of improving organisational arrangements to reveal instances of harm in recent years.

Options

Option 1: do nothing. Ethically, morally and professionally, health and care professionals are already required to tell people about incidents resulting in harm. This duty would remain although there would be no statutory or legal duty on organisations to support a reliable process to reveal incidents resulting in harm.

Option 2: to Introduce a Statutory Duty of Candour for organisations providing Health and Social Care. The statutory or legal duty will ensure that organisations must act in an open and transparent way with people when things go wrong. It will describe the minimum requirements that must be in place to support this introduction and report on how the process will work.

Requirements for Health and Social Care Organisations

1. As soon as it is reasonably practicable after becoming aware that there has been an incident resulting in harm, the organisation must make sure that the relevant person is told that this has happened. This will involve a step by step account of the facts of the incident being provided, including as much or as little information as the person wants.
2. There must be an offer of reasonable support provided to the patient, relatives and staff who have been involved with the incident.
3. The responsibility will rest with organisations to make sure that all staff, who are asked to be involved with revealing the incident, have access to the relevant training, supervision and support before, during and after their involvement.
4. When the relevant person is told this should be done in person by a suitably trained representative of the organisation and should include an account of all of the facts known about the incident at the time of it being revealed and the plans for the incident to be reviewed. It will be for the organisation to determine who is most appropriate to reveal the incident that has resulted in harm.
5. The relevant person must be told of the further steps to be taken in reviewing the incident and be given the opportunity to have their questions taken onboard when the incident is reviewed.
6. The organisation must provide an apology and must confirm all of the actions taken in a written record, the contents of which will inform the quarterly report.
7. The relevant person must also receive a written summary of the face to face meeting.

Reporting on Disclosure Arrangements

1. All organisations must report publically on a quarterly basis the nature of incidents that have been revealed to people and confirm that requirements of the organisational duty of candour (honesty) have been met.
2. Organisations must also report on how they have supported staff in obtaining and maintaining the skills required to make sure that the relevant person is treated with respect by the staff involved.
3. Organisations should also publish annually their policies and procedures to support openness and transparency; this must include the processes in place to support staff training and development to handle these incidents. These reports should be submitted to the relevant organisation (which will differ for each organisation).
4. Organisations would be required to make sure that they have processes in place to make sure that if any incident is reported that it is reviewed and a decision made on whether this is an incident that should be revealed to the relevant person.
5. Organisations must also include a summary in their reports of the support that is available to patients, families and staff following an incident resulting in harm. They would also need to describe how best practice is used when incidents occur.

Sectors and groups affected

The statutory duty of candour would apply to health and care services provided by NHS Boards, Local Authorities, all organisations providing services regulated by the Care Inspectorate, independent hospitals, independent hospices, General Practices, community pharmacies, dental practices and optometry practices.

Any or all patient/clients, and their families, treated in a formal healthcare setting could be affected. As this is an organisational duty, it would not apply to individuals providing services, for example, childminders.

Question 1: Do you agree that the processes, that should be in place to support an organisational duty of candour, should be described in detail?

Question 2: Should the organisational duty of candour cover the need for adequate provision be in place to make sure that staff have the support, knowledge and skill required?

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

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

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

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

Question 5: What staffing and resources would be needed to support effective processes for the reveal of instances of harm?

Disclosable or applicable event or incident

Disclosable or applicable incidents would be defined as unintended or unexpected incidents that occurred or was suspected to have occurred that resulted in death, injury or long-lasting physical or psychological harm being experienced by a user of health and/or social care services.

Disclosable or applicable incidents with regards to health care would involve the death of someone receiving care where the death relates to the incident itself (not due to the natural course of their illness or underlying condition).

Disclosable or applicable incidents involving harm that involve the permanent reduction of bodily, sensory, motor, physiological or intellectual functions (including removal of the wrong limb or organ or the occurrence of brain damage) would be applicable.

Returns to surgery, an unplanned re-admission to hospital, a long-lasting period of care, extra time in hospital or as an out-patient, cancellation of treatment or transfer to intensive care should also be included within the range of incidents that result in harm.

Long-lasting pain and long-lasting psychological harm also needs to be taken into account when detailing incidents of harm (e.g. a continuous period of 28 days).

The shortening of the life expectancy of someone using social care services would be applicable. The occurrence of an injury that if left untreated would lead to death, impairment, harm or shortened life expectancy would also be applicable for social care providers. This would not include a shortening of life expectancy as a result of a long-term condition where this is an expected outcome.

Children's social care services, alongside keeping children safe, are above all focused on a child developing as well as they can and reaching his or her full potential. Decisions taken to allow that, such as taking children into care, may have unintended consequences, though it may not always be possible to connect the trauma to any particular action.

Question 6a: Do you agree with the applicable incidents that are proposed?

Question 6b: Will the applicable incidents that are proposed be clearly appropriate and identifiable in all care settings?

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

Question 7: What are the main issues that need to be addressed to support effective methods to decide if an incident that results harm has occurred?

Benefits

Option 1: do nothing

There would be no change to current policies and practice or to individual professional responsibilities. There would be no additional benefits.

Option 2: to Introduce a Statutory Duty of Candour for Health and Social Care

The legislation aims to make providers of health and social care increase transparency and openness in the organisation, creating a workplace in which staff are supported to report incidents where harm may have been caused. Staff will be encouraged to speak candidly to service users and/or relatives in the event of harm (including death) resulting from treatment.

This will reduce the level of distress and frustration that people experience when they do not receive the information that they're seeking. This benefit is unquantifiable.

It is expected that to start with there will be an increase in the number of reports of incidents. This should result in better awareness of patient safety and ultimately a reduction in avoidable incidents of harm. This benefit is difficult to quantify.

Overall, a requirement which encourages openness and honesty across all organisations within the health and social care sector may increase both staff and patient satisfaction. This benefit is difficult to quantify.

Enforcement, sanctions and monitoring

Option 1: this option would require no additional monitoring or enforcement.

Option 2:

Monitoring and enforcement: organisations will be expected to report quarterly on all applicable incidents including information on the processes in place to deliver duty of candour and the learning and improvement that has come about due to these incidents.

The aim is to use the existing agencies within Scotland that have a duty to regulate health and social care organisations; these are the Scottish Government, Healthcare Improvement Scotland and the Care Inspectorate. Particular sections of the health and social care market would report to assigned agencies. These proposed arrangements for reporting and monitoring are part of the consultation and the Scottish Government would welcome comments on these.

Sanctions: a decision on possible sanctions and/or penalties has yet to be reached. The Scottish Government invites, through the consultation, suggestions on possible sanctions for not complying with a duty of candour.

Implementation and delivery plan

15 October 2014 - 14 January 2015

Consultation launch

Publication of Partial BRIA & EQIA with consultation document October 2014

Engagement with stakeholders including health professionals, health boards, care home providers

Post-implementation review

Any review process will be considered as the legislation is developed.

CONSULTATION QUESTIONNAIRE

Question 1: Do you agree that the processes that should be in place to support an organisational duty of candour should be described in detail?

Yes

No

Comments:

Question 2: Should the organisational duty of candour cover the requirement that adequate provision be in place to make sure that staff have the support, knowledge and skill required?

Yes

No

Comments:

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

Yes

No

Comments:

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

Yes

No

Comments:

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

Yes

No

Comments:

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

Yes

No

Comments:

Question 5: What staffing and resources would be needed to support effective processes for the reveal of instances of harm?

Yes

No

Comments:

Question 6a: Do you agree with the applicable incidents that are proposed?

Yes

No

Comments:

Question 6b: Will the applicable incidents that are proposed be clearly appropriate and identifiable in all care settings?

Yes

No

Comments:

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

Yes

No

Comments:

Question 7: What are the main issues that need to be addressed to support effective methods to decide if an incident that results harm has occurred?

Yes

No

Comments:

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

Yes

No

Comments:

Question 9: What should be the consequences if it is discovered that an applicable incident has not been revealed to the relevant person?

Yes

No

Comments:

End of Questionnaire