



Care Inspectorate response to the Scottish Government consultation on proposals to introduce a statutory duty of candour for health and social services.

Introduction

The Care Inspectorate is the independent scrutiny and improvement body established under the Public Services Reform (Scotland) Act 2010, which brings together the scrutiny work previously undertaken by the Care Commission, HMIE child protection team and the Social Work Inspection Agency. Our role is to regulate and inspect care and support services (including criminal justice services) and carry out scrutiny of social work services. We provide independent assurance and protection for people who use services, their families and carers and the wider public. In addition, we play a significant role in supporting improvement in the quality of services for people in Scotland.

We welcome the opportunity to respond to this consultation and would be happy to be involved in any future discussions.

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 No

In principle we support the proposal, but have some concerns regarding its implementation and some questions around whether such a duty might have some unintended consequences.

We feel that the “organisational” nature of the proposed duty raises some issues. The consultation states that the duty would not apply to individuals, using childminders as an example. While it is true that most childminders are individuals, they do not have to be, and some are not. This issue is even more pertinent in relation to other types of service regulated by the Care Inspectorate, such as care homes, some of which are operated by

organisations which would be subject to the duty and some of which are operated by individuals who would not. We are concerned at what appears to be a potentially arbitrary distinction between the levels of protection afforded to people, who are equally vulnerable and receive the same type of care service, simply depending on whether the care service they receive is provided by an individual or an organisation.

We also have a degree of concern that the creation of the proposed duty will encourage “defensive practice”. For example, this might include frequent or inappropriate hospital admissions from care homes, or care services limiting the degree or complexity of needs they are prepared to cater for.

We suggest that the duty of candour be introduced as a common element in the new National Care Standards which are focused on human rights.

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 No

We agree, on the basis that the support, knowledge and skill referred to is appropriate to properly implement the proposed duty of candour. Assuming that is the case, it is essential that staff are properly equipped to implement the duty.

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

Yes No

We have answered neither “Yes”, nor “No” to this question as we feel that further clarity is required. The consultation paper suggests that reporting is to be on “the nature” of adverse incidents, while the question may suggest that reporting will be on individual incidents.

We suggest only reporting on “the nature” of adverse incidents, for several reasons. Firstly, it will be important in any public reporting regime, to ensure that individuals’ confidentiality is preserved. Secondly, while our response to question 1 notes our concerns that the proposed duty might encourage “defensive practice”, we also suggest that a requirement for public reporting which is too onerous may encourage those subject to the duty to seek to, for example, ensure that as few incidents as possible are regarded as being

“caught” by the duty. This highlights the importance of careful drafting to ensure clarity regarding the expectations placed upon providers of services, and consistency as to what falls within the duty.

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

Yes No

We agree but emphasise the importance of defining “harm” and addressing what constitutes an “adverse incident”. Clarity is also required in relation to how it is expected that those subject to the duty will address the issue of causation – the consultation refers to an “adverse event resulting in harm”.

Further, we suggest that consideration be given to an exception to the requirement to disclose, where to do so would result in psychiatric injury to the person harmed.

See also our response to Question 7.

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

Yes No

We have answered neither “Yes” nor “No” to this question as we are concerned that the proposals are rather vague.

However, we note that the requirement includes a requirement to apologise. We would suggest that taking together an acknowledgement that there has been an “adverse event resulting in harm” and the issuing of an apology, it may be argued that an admission of fault has been established. It will be important to ensure that the proposed statutory regime does not leave those providing care legally obliged to risk incurring liabilities in damages where they do not admit fault. We also note the concurrent consultation on a proposed offence of Wilful Neglect or Ill-Treatment in Health and Social Care Settings and suggest that a potential tension may arise between providers’ duties to disclose and their right not to self-incriminate.

Question 4:

What do you think is an appropriate frequency for such reporting?

Quarterly Bi-Annually Annually Other (outline below)

We feel that annual reporting is the most reasonable and practical option, particularly bearing in mind that, where regulated care services are concerned, many matters which might qualify as disclosable events will be reportable to the Care Inspectorate as the regulator in far shorter timescales (within 24 hours in some cases).

Question 5:

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

We feel that others may be better equipped to respond to this question than we are. However, should the duty of candour legislation come into force, the role of the Care Inspectorate would need to be clarified and direct involvement may have resource implications.

Question 6a:

Do you agree with the disclosable events that are proposed?

Yes No

We have answered neither "Yes" nor "No" to this question. While on the face of it, the events detailed appear appropriate, we feel that they are most readily identified in a healthcare setting. If these events are used as the basis for the proposed duty, there is likely to be some ambiguity in social care settings as to whether a disclosable event had occurred. Please see our response to Question 6b in this regard.

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

Yes No

We feel that the disclosable events proposed would be potentially difficult to identify in social care settings, particularly in care homes where service users are often very frail and may suffer from a range of complex conditions. In relation to such individuals, it may be very difficult to determine where the cause of deterioration in their condition, shortening of life expectancy, or even death, lies.

In addition, further consideration should be given to the definition of disclosable events and in particular the adverse events resulting in harm, to ensure the thresholds proposed are aligned with those currently used by social care services to report on harm. There may be a risk that social care organisations adopt a higher threshold, with an unintended consequence that less harm is actually reported. Currently the public protection

framework expects services to report all potential harm for statutory investigation and also to refer any individual staff who have harmed users or placed them at risk of harm.

Question 6c:

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

See 6b above. In addition, consideration should be given to the current arrangements for care services to notify the Care Inspectorate of specific accidents, incidents and other matters. Different thresholds and lack of alignment of all "disclosable events" may be confusing to providers and therefore creates a risk of under or non-compliance with both systems.

There are significant differences between our criteria and the proposed definition of a disclosable event as one that resulted in death, injury or prolonged physical or psychological harm. For example, many notifiable incidents/accidents, which result in a hospital or GP visit, but do not result in death, injury or prolonged physical or psychological harm are reported.

To require every nursery, playgroup and out of school club to publically report every notifiable incident/event, which will not necessarily indicate that the service has done anything wrong, seems unnecessary for improving services or giving public assurance and could have unintended consequences.

We would suggest that the implications of this proposal for Education Departments be considered. They will be required to comply for their nurseries (and any out of school clubs), but not for primary and secondary schools. In terms of the aims of the proposal, this seems anomalous.

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?

The definitions adopted will be critical, whether the need for disclosure is defined by reference to "adverse events" and "harm" or a more prescriptive list of "disclosable events". It is not clear from the consultation which of these approaches is being proposed.

Question 8:

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

We note that it is proposed that monitoring be carried out using existing performance monitoring, regulation and/or scrutiny arrangements. In the

case of social care, this would involve the Care Inspectorate in monitoring of these arrangements. The Care Inspectorate currently requires reporting of a range of incidents or events that occur in a care service and it would be important to avoid any confusion in the understanding of those we regulate.

Monitoring of compliance with the duty of candour has the potential to be onerous, and we suggest that there be no overt requirement to monitor compliance at every inspection of a care service. The Care Inspectorate must retain the flexibility to undertake inspections of appropriate duration and intensity as it considers necessary, proportionate and justified, having regard to available intelligence and its own assessment of risk.

We also feel that, in relation to the range of “disclosable events” suggested in the consultation, there should be a mechanism for the Care Inspectorate to become involved in assessing whether or not a matter should have been disclosed. That may involve coming to a view as to whether or not a particular set of circumstances constituted a “disclosable event”. This in turn may require the Care Inspectorate to make judgements upon a range of complex medical issues, including coming to a view as to whether a particular event has caused a deterioration in the condition, the shortening of the life, or even the death, of a very vulnerable person who may have been suffering from a range of complex conditions. We feel that discussion is required around whether the Care Inspectorate is currently equipped or resourced to carry out work of this nature.

Question 9:

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

The obvious suggestion is that non-compliance should be an offence. It may be, however, that publicity around the failure to disclose (popularly referred to as “naming and shaming”) may be a sufficient consequence to act as a deterrent to future failure. That apart, it is difficult to envisage a consequence which might be applied across the wide range of service types and provider types to be covered by the proposed duty. We suggest that a combination of publicity in the first place, with an offence relating to persistent failure, might be a solution.