Finance Committee

Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill

Submission from Healthcare Improvement Scotland

Response

Healthcare Improvement Scotland responded to the Scottish Government consultations on both the Duty of Candour and Wilful Neglect proposals. This submission focuses on the financial assumptions in relation to the duty of candour provisions, as set out in the Financial Memorandum (FM), and supports our written evidence to the Health and Sport Committee on the Health Bill.

We welcome that the FM recognises the recurring financial impact of implementing the duty of candour provisions. In our response to the Scottish Government consultation on the duty of candour we stated that the time and resources required to ensure staff are appropriately skilled and supported to manage open and honest conversations with patients and their families cannot be underestimated. To achieve the intent of the duty of candour will mean widespread cultural change which is challenging and will take time.

The financial impacts of the Bill have been broken down into the main elements of the procedure and we have structured our comments against these; however our main points relate to the costs of training and implementation within NHSScotland.

Disclosure, apology and review

The FM references the framework we first published in 2013, ‘Learning from adverse events through reporting and review’, which sets out guidance for Scotland for effective management of adverse events including disclosing, apologising and reviewing adverse events. A programme of work is underway nationally and locally to implement this framework and NHS boards are making a number of improvements. However, dependent on the duty of candour procedure, to be detailed in future regulations, NHS boards may be required to make changes to their existing systems and processes. This is difficult to quantify at this stage but is likely to have a resource implication specifically around capacity and capability.

Training and implementation

We welcome that the FM is explicit that training and support for implementation of the duty of candour provisions will be required for staff. We are also supportive of the development of national resources that all organisations can use to support implementation of the duty.

The FM also states that the Scottish Government anticipates that NHS boards will be able to incorporate the requirements for the duty of candour procedure within their existing processes to support staff training and induction programmes. While
awareness raising and outlining of roles and responsibilities can be incorporated into existing training processes, if we are to truly support staff and build their capacity and capability to be open and honest with people about their care then additional investment is likely to be required.

Our recent experience of supporting the ‘Being Open’ pilot in the maternity department at Edinburgh Royal Infirmary (part of the implementation of the national framework for learning from adverse events) has shown that specialist communication training for staff, tailored to their specific service, has been essential to provide staff with the appropriate skills and support to manage open and honest conversations with patients/service-users and their families.

This pilot has provided training for 46 members of the clinical team, including consultants, senior trainees, nurses and midwives, and seen improvements in safety culture, patient experience, staff experience and the adverse event management process (specifically open disclosure and involvement of patients and families in the review process). The following quotes demonstrate the impact of this work for both patients and staff:

“We found it extremely useful to be able to discuss things … with Dr X, Dr Y and a member of the midwifery team. We understand this was part of a trial initiative to communicate with patients after more serious incidents, but we found it extremely useful and we really appreciate the extra time it took out of these staff members’ days to talk us through events and answer questions at length.” Extract from letter written by a patient

“We were treating a patient with (condition), who was extremely sick and unfortunately didn’t make it. The staff involved in treating the patient (doctors and nurses) and involved in the resuscitation were quite upset afterwards. However Dr A was the attending consultant, and she was extremely supportive both throughout and after the resuscitation. She invited us all for a debrief afterwards to discuss the resuscitation, and asked if we had anything we wanted to ask or share. It is not often we get this support from senior staff, and all the nursing staff appreciated this a great deal.” Extract from email sent to Dr A after a staff support debrief

The resource requirements of the pilot include: a project team; staff time to attend training, to test process improvements and to spend more time communicating with patients and families; development of support materials such as patient information and a communication guide for staff. The cost of the pilot for one year has been around £60,000 (this does not include freeing up of staff time). Therefore in this pilot the cost to appropriately train and support staff has been around £1,300 per member of staff. Once further developed and tested the costs of this model is likely to reduce, however, it is clear to train and support staff to implement the duty of candour will require investment.
Monitoring

Healthcare Improvement Scotland is specified as the monitoring body in relation to independent healthcare services. The FM states that the Scottish Government anticipates there will not be any additional costs as monitoring will be incorporated into existing processes. This will require changes to existing systems and processes but we do not anticipate there will be any significant costs associated with this additional role.

However in our submission to the Health and Sport Committee we ask that the bill is amended to clarify that we are the monitoring body for those independent healthcare services that we regulate i.e. within the meaning of Section 10F(1) of the 1978 Act and where the legislative powers for regulation have been commenced. This is an important distinction which would have significant resource implications for Healthcare Improvement Scotland.