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

Simpson & Marwick

1. Do you support the Bill's provisions in relation to NVPs?
   No opinion.

2. Do you support the proposal to ban smoking in hospital grounds?
   No opinion.

3. Is there anything you would add/remove/change in the Bill with regards to NVPs or smoking in hospital grounds?
   No opinion.

4. Do you support the proposed duty of candour?
   We support the concept of a statutory duty of candour. However, we have serious concerns over the duty as set out in the Bill.

   There is a need for openness within organisations. That must reflect the need for blame-free reporting of incidents; the opportunity to review and learn from them; and the scope to ensure those affected are informed and involved. Many organisations have such measures in place. However we do not support the use of regulation where it adds to the compliance-driven culture where the letter of the law is followed but not the spirit and is therefore an inappropriate instrument to address the lack of an open culture.

   The proposed duty is immense in its breadth. Compliance would be crippling, a serious drain on resources for health and social care providers and on the time of professionals.

   The definition of incidents which activate the duty of candour procedure is so wide as to result in a very significant drain on staffing and resources. Using a definition of events that includes those which, in the reasonable opinion of a registered health professional, could result in an outcome mentioned in section 21(4) is so broad as to encompass very minor events which are part of the day-to-day routine of healthcare provision. While many incidents that occur may be possible expected outcomes, due to the experience of the health professional involved, these incidents are all likely to be unintended. Healthcare professionals do not intend to cause any of the outcomes listed in section 21(4). The use of the term *unintended incident* is so broad as to be meaningless.

   It is our concern that the bill will require the duty of candour procedure to be followed in a large amount of foreseeable situations. Section 21(2)(b)(ii) does not provide an adequate protection and requires to be strengthened. It ought to cover the foreseeable outcomes of treatment as well as the natural course of an illness or condition.

   The definition of non-severe harm as including an increase in the person’s treatment is exceptionally broad. Does an increase in the person’s treatment include an increase of time spent under the care of a health, care, or social
work service? Resource issues often lead to planned treatment being cancelled and thus treatment length increases. The definition gives no consideration to context. It would be inappropriate for hospital staff to spend time reporting disclosable events when treatment had been cancelled to allow staff to deal with a spike in A&E attendances, for instance.

Further, we do not support the procedure set out in section 22 and the reporting system in section 24. The proposed procedure, linked with the above, provides for an extensive administrative system to monitor this procedure. When health, care, and social work provision is already under such pressure and time is at a premium, the reporting requirements are out of all proportion. The scope of the regulations to be made under section 22 is very wide and allows for regulations that will place a significant burden on the responsible person.

Any person harmed by the provision of health or social care ought to be informed of that. However the information ought to be provided only when it will not cause the relevant person harm, and where disclosure is in the interests of the patient. The scope provided for the regulations creates a risk that the responsible person will actively pursue the relevant person to inform them in order to comply with the regulations, even where this may not be in the patient’s best interests.

For any statutory duty to be effective there need to be systems for reporting and monitoring compliance, and sanctions for non-compliance. Any such system will inevitably distract from the original objective of ensuring openness with patients and learning from mistakes. The low threshold of activation incidents will place undue pressure on practitioners to make these more subjective judgments knowing their decision could entail a statutory obligation to report the incident. It will lead to confusion, inconsistency and fear amongst professionals.

While we agree that there is a need to promote an atmosphere of openness and culture of candour within health, care and social work services, we do not agree that this legislation is the appropriate method to achieve that aim.

5. Do you support the proposal to make wilful neglect or ill-treatment of patients a criminal offence?
We do not support the proposal to make wilful neglect or ill-treatment of patients a criminal offence. The intention expressed here is to create an offence similar to that which exists for mental health patients under section 315 of the Mental Health (Scotland) Act 2003, and for adults with incapacity under section 83 of the Adults with Incapacity (Scotland) Act 2000. However, these provisions exist to protect vulnerable groups without capacity or with limited capacity in circumstances where they are accordingly unlikely to be able to use or invoke the existing complaint, regulatory and disciplinary systems to address sub-standard care, and yet those providing care are likely to have rights and obligations to take decisions for them.

It is not clear why there should immediately be considered a need to provide for a similar sanction for adults with capacity, who are making decisions about
their own treatment and are likely to be able to engage with existing complaint, disciplinary and regulatory systems. Following the consultation paper, it is still not clear how the current systems which exist are lacking to provide the protection required for adults with capacity.

It is respectfully suggested that an additional criminal sanction applied in cases involving adults with capacity will not assist in the protection of those individuals, they merely add to an increasingly punitive environment. Instead, a more thorough examination of the existing leadership, training and mentoring systems, and also of regulatory, disciplinary and complaint systems is warranted to identify how such situations can arise nonetheless and how these systems can be developed to stop that occurring again; prevention rather than sanction after the event.

We are concerned by the lack of a definition of either ill-treatment or wilful neglect. Wilful neglect is such a broad term that it will encompass acts which are properly, reasonably and responsibly undertaken. Thus a responsible decision not to allocate resources, to provide certain treatment or to prioritise certain patients would be wilful and would amount to neglect. If there is any justification for such an offence at all, it should only be where there has been serious harm or death in consequence. There is otherwise the considerable risk of creating increased fear and a culture of hiding errors. Regulatory and disciplinary procedures are already well-designed to deal with more minor issues.

The offence also covers ill-treatment, which need not be wilful. The lack of definition is again troubling. The offence could conceivably cover incidents of genuine mistake or accident. The imposition of criminal sanctions in these circumstances seems an overreaction when there are already regulatory and disciplinary systems in place to deal with them. It is our view that the focus should be on improving services, evaluating and learning from mistakes that do happen.

We consider that there is no justification for the proposed offence at all. However, if the offence is created it should only apply to organisations where a duty of care was owed to an individual; there was a gross breach of that duty by the organisation; there was no reasonable excuse for the breach; and it resulted in serious harm or death.

The current definition of a care provider offence is similar to our suggested application. However, again the lack of definition of wilful neglect or ill-treatment causes concern. This allows for a wide interpretation, creating a serious risk of clinical and operational decisions not being taken in the best interests of all service users, but rather with a view to avoiding prosecution.

The provision in the bill allowing the court to make remedial orders is welcome, as this will facilitate service improvement. Considering the Mid-Staffordshire Inquiry recommendations, to impose a criminal sanction as a basis for punishment without any of the benefit of the positive frameworks for support and leadership of those who could potentially be held to account
under the sanction is ill-conceived. It is our view that remedial action should be a greater focus in this bill.

We consider that the availability of a publicity order is contrary to the promotion of an environment of quality health and social care. The publication of the fact that a care provider has been convicted of the offence does not, in our view, do anything to improve the service or make changes to bad practice. Instead, we believe that this increases the risk that organisations will attempt to hide these occurrences rather than learning from them. The focus should be on prevention, organisational change, and improving health and social care service.

Finally, we do not agree that there should be summary conviction for a care worker offence. Given the likelihood that a conviction would be career-ending for any professional, the offence should be triable on indictment only.

6. Is there anything you would add/remove/change in the Bill with regards to these provisions?

With regards to a duty of candour, instead of legislation, time and effort would be better spent on a framework for the blame-free reporting of incidents of genuine seriousness. If legislation is pursued, then it is essential that the definition of an incident which activates the duty of candour procedure is limited and better defined. Further, limiting the procedure and reporting processes so as to not place such a large burden on organisations is preferred.

Turning to the offence of ill-treatment and wilful neglect, we raise serious concerns about the lack of a definition of these offences. If they are to be included then we recommend providing for a definition that is restricted to those actions which cause serious harm or death. It is our view that this part of the bill should focus more on the remedial actions and support needed to facilitate change, and less on punitive sanctions. Further, we recommend removing the provisions regarding the publicity order. This part of the bill is misconceived and is out of line with the focus of improving adult health or social care. It is our view that the risk of having to publicise such information – further than it will be ordinarily publicised – will not encourage an open culture of honesty.

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