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

Action against Medical Accidents (AvMA)

Introduction

Action against Medical Accidents (AvMA) is the UK charity for patient safety and justice. It is registered as a charity in Scotland (number SCO 39683) and in England and Wales (number 299123).

AvMA is pleased to provide comments to the Health and Sport Committee in relation to the Bill’s provisions for a Duty of Candour and for a criminal offence of Ill Treatment and Wilful Neglect, which touch directly on AvMA’s charitable objectives.

AvMA has campaigned for a statutory Duty of Candour across the United Kingdom for some 20 years and is widely credited as having done more than any other organisation to raise awareness of the need for a Duty of Candour and to influence policy makers towards setting the Duty of Candour on a statutory basis. AvMA was a core participant in the Mid Staffordshire Public Inquiry and provided evidence to Sir Robert Frances QC on (inter alia) the need for a statutory Duty of Candour. AvMA has worked closely with Ministers and the Department of Health in England and the Care Quality Commission over the development of the Duty of Candour as it now applies in England and how it is to be developed and implemented.

The Duty of Candour as provided for in the Bill

AVMA very much welcomes the fact that the Bill will put a Duty of Candour on health and care organisations in Scotland on a statutory basis. Our comments will focus on where we think this section of the Bill can be improved, and what else is needed to make its implementation successful. We believe if it is introduced in the right way, the Duty of Candour will represent the biggest breakthrough in patient safety and patients’ rights in Scotland’s history and put Scotland amongst the world’s leaders in its approach to patient safety. AvMA does have some major concerns about how the Bill as currently drafted deals with the Duty of Candour. These and other comments are dealt with below.

Potential Harm

We were glad to set the wording under clause 21 includes the words “appears to” or “could result in” is the definition of incidents which activate the duty of candour procedure. The policy intention is clearly that known incidents which “appear” to have resulted in certain levels of harm (rather than those that have conclusively been found to have) are covered by the Duty of Candour. Also, that incidents where harm does not yet appear to have resulted but has the potential to, are covered. We believe there is wide consensus that this should be the case, and this has certainly been the conclusion of work on the Duty of Candour in England. We believe that the subsequent wording of the
clause needs to be amended to avoid any ambiguity or confusion about this.
In particular:

- 22 (4) (c) should be amended to read “(c) harm which is not severe but which could result in .....”

- 22 (2) (G) (ii) should be amended to read “that outcome may relate directly to the incident rather than to the natural course of the person’s illness or underlying condition.”

Definition of “Incidents which activate the Duty of Candour procedure”

We believe that the Bill should better define “incident which activates duty of candour procedures” so as to make it clear that “omissions” in care or treatment are covered by the Duty of Candour. At present, the wording of the Bill could be interpreted as only covering incidents where there has been active treatment or care. Many untoward incidents which lead to significant harm are as result of “omissions” – a failure to diagnose and treat appropriately. It would clearly be wrong to allow such incidents not to be covered by the Duty of Candour. We believe this can be easily rectified by changing the wording in this part of the Bill, or adding a definition under (25) “interpretation of Part 2”, to make it clear that incidents of failure to diagnose/late diagnosis, of failure to treat appropriately/delayed treatment are covered.

In England, after much debate and deliberation, consensus was reached that incidents which have or could result in “significant harm” should instigate the Duty of Candour procedure. We would suggest that use of the phrase “significant harm” within the Bill would add clarity and re-enforce the principle that any significant or potentially significant harm incidents are covered. This can be further clarified by the guidance.

Sanctions/Consequences of Non-Compliance

We firmly believe that the most important benefit of putting the Duty of Candour on a statutory basis will be that it will underpin cultural change and make being open about incidents second nature in health and social care. However, to have the necessary impact, it needs to be seen that failure to comply would have serious consequences for the health or care provider. Unless we have misinterpreted the Bill as currently drafted, it would appear that the only consequences for a provider who fails to comply is that “Scottish Ministers, Health Improvement Scotland and Social Care and Social Work Improvement Scotland may publish a report on compliance of this part by responsible persons” (24 (8) ).

We strongly recommend that the Bill should put a statutory duty on the above parties to investigate suspected non-compliance and where appropriate to use the powers at their disposal to demand compliance and where appropriate take regulatory action against the provider. In England, the Care Quality Commission has statutory powers to issue warnings; put
providers under special measures; fine providers; withdraw provider’s registration to provide health or social care; or prosecute providers.

Other Suggestions

Under “(24) Reporting and Monitoring” we recommend that training provided to staff on compliance and good practice is made a mandatory subject to report upon.

Under 24 (4) we recommend that the core requirements are set out in regulations rather than left to the providers discretion and that this is reflected under 22 (2).

We recommend that the Bill should place a statutory duty on health and care providers to nominate a suitable senior member of staff to take a lead in compliance with the Duty of Candour including making sure suitable training and support is available and monitoring/reporting to the Board or partners. This Duty of Candour applies to organisations but even in organisations that do their best to comply, an individual within an organisation may cause non-compliance. Bearing this in mind, we recommend that the Bill itself or the regulations require the organisation to take appropriate disciplinary action against individual staff who cause non-compliance, and where that person is a registered health professional, refer them to the relevant professional regulator.

We question the approach of the Bill in 21 (3) of stipulating that a health professional who has not been involved in the incident is always required to give an opinion on whether the incident should activate the Duty of Candour procedure. We believe this would have unintended consequences in that it would:

- Mitigate against the treating health professional(s) acting according to their own professional obligations and acting quickly and appropriately to give open and honest explanations to the patient.

- Create an unnecessary level of waste/bureaucracy in complying with the duty by requesting an independent health professional is found to give an opinion on each and every incident which should potentially activate the duty of candour procedure.

The spirit of the Duty of Candour is that where there is a suspected incident giving rise to potential or actual significant harm, the Duty of Candour procedure is activated as soon as it is practical and appropriate to do so. The regulation in England uses the words “in the opinion of a registered health professional” in its definition of a notifiable safety incident, but does not literally mean that the decision to activate the notification procedure has to be taken by an individual health professional who was not involved in the incident.

The reference to the opinion of a registered health is, we believe, useful as a benchmark as to what should activate the procedure. In other words, we are
talking about incidents which “would” in the reasonable opinion of a registered health professional meet the definition. The provider should bear this in mind and may on occasions need to consult with a health professional, who is not involved in the incident, but this should not get in the way of any health professional or non-health professional doing what should come naturally – being fully open and honest and doing so with good practice. We believe here issues of good practice are better dealt with through guidance.

**Ill Treatment and Wilful Neglect**

We support the principle of a criminal offence gross poor treatment and wilful neglect in a similar fashion as has been created in England. Our concern is that it is only that egregious and wilful departures from acceptable practice are captured and that the offence should apply to management – those with overall responsibility for maintaining standards – as well as individual care providers.

**Action against Medical Accidents**