Citizens Advice Scotland

The Citizens Advice Service

Citizens Advice Scotland and its CAB offices form Scotland’s largest independent advice and advocacy network. Citizens Advice Scotland (CAS) is the umbrella organisation for Scotland’s network of 82 Citizens Advice Bureau (CAB) offices. These bureaux deliver frontline advice services throughout over 200 service points across the country, from the city centres of Glasgow and Edinburgh to the Highlands, Islands and rural Borders communities.

The Patient Advice and Support Service, delivered by CAB in Scotland was established in April 2012 to

(a) promote an awareness and understanding of the rights and responsibilities of patients (and in particular, promote awareness of the Charter),

(b) advise and support persons who wish to give feedback or comments, or raise concerns or complaints about health care,

(c) provide information and advice on such matters as it considers likely to be of interest to persons using the health service,

(d) make persons aware of and, where appropriate, direct them to—

(i) other sources of advice and support (including persons who provide advice and support in relation to matters other than the health service),

(ii) persons providing representation and advocacy services, ¹

Between April 2012 to March 2015, 7,345 citizens advice bureaux clients were supported with 21,463 issues related to NHS feedback, comment, concerns and complaints. The evidence from these enquiries tells us a lot about clients’ experience of the NHS in Scotland. The following paragraphs use this evidence to show the difference it can make to clients when the NHS provide an explanation of what happened during their treatment, or that of the person they are raising an issue on behalf of.

All of the case studies used in this response are from clients who sought advice from a citizens advice bureau in 2014/5.

This response only relates to Part 2 of the consultation, and only to health.

4. Do you support the proposed duty of candour?

¹ Patient Rights (Scotland) Act 2011
Yes. While CAS would hope the NHS would be open and honest about such incidents, creating a duty upon them clarifies the situation and gives the public greater protection as long as it is then easy to take action against the NHS for breach of that duty. CAS believes that a duty of candour can only be positive when it comes to the public receiving information about their or their family members' treatment, ensuring lessons are learned and those affected are made aware of any unintended or unexpected incidents.

When the specialist Patient Advisers in citizens advice bureaux first meet with clients they discuss the outcomes the client hopes to achieve by raising a concern or complaint with the NHS. Many clients hope to receive an apology, and in some Health Boards these are frequently given. Many clients want their experience to lead to a change in practice so that whatever has happened to them doesn't happen to anyone else. Some Health Board areas are very open and provide detailed explanations which our clients find very helpful at putting their mind at ease. Where an explanation is not provided, or no information is provided about actions taken to rectify a situation, for example, discussing the issues at staff meetings or providing training, this can be frustrating for the clients who still don't know or understand what has happened. In some cases, clients go to the Scottish Public Services Ombudsman (SPSO) in the hope of receiving a satisfactory explanation. If there was a duty on the NHS to provide this information at an earlier stage, it is hoped that clients would not have to go through the stress of taking their cases to the SPSO.

The following cases show examples of clients who, as a result of their own concerns, have used the NHS complaints process. The clients have received apologies and explanations of what has happened to them which had been invaluable to them.

**Case study 1**

The client felt his condition was not being managed properly by his GP practice. The client also had concerns that the GP practice failed to refer him to Dermatology as previously recommended by a Hospital Consultant. The Patient Adviser and the client wrote a letter of complaint to the practice.

The response indicated a failing in communication and that the treatment provided could have been better addressed. The practice apologised to the patient and said that a practice meeting will be held to establish a more robust way of managing patients with his condition and to address the way in which the practice communicates with their patients. The client was satisfied with the findings and the intended actions.

**Case study 2**

A client's test results were given by the practice nurse to a family member with the same name instead of the client. The client felt that her confidentiality had been breached. After being supported to raise a complaint by PASS the client received a response from the GP practice apologising for the error. The client was also assured that all staff had been reminded of the importance of checking full details before giving out information over the telephone. The
client was satisfied with the response.

**Case study 3**

The client stated that she had fallen at home and injured her arm and leg. The client attended the Accident & Emergency Department where a fractured collarbone was diagnosed. No diagnosis was given for the leg injury. The client returned to hospital two weeks later where a fracture to the leg was diagnosed. The Patient Adviser supported the client to write a letter of complaint.

The NHS investigation showed that the Emergency Nurse Practitioner (ENP) focused more on the collarbone and sincerely apologised for this failing. The ENP also gave assurances that a valuable lesson had been learned. The Consultant concerned also apologised that he too missed the fracture and has reflected on the client’s comments. The client accepted the finding and apologies offered.

CAS believe that the honesty and openness of the NHS in these examples has helped the clients to gain a better understanding of what has happened, and be assured that this will not happen again. If more NHS staff felt able to offer an explanation and apology this would be beneficial for both the client and the NHS staff involved as it could lead to issues being dealt with and resolved earlier. This is particularly the case for those clients who use the service following bereavement as in the examples below.

**Case study 4**

Following the death of her daughter, a client contacted the Patient Advice and Support Service for assistance to make an NHS procedure. The client was unhappy with the response from the NHS and advised that she would like to meet with senior staff.

The Patient Adviser supported the client at a meeting with senior staff. The client received a full explanation for the treatment her daughter received. The client was emotional but satisfied with the explanations offered.

**Case study 5**

A family wished to raise a formal complaint relating to their father’s treatment and subsequent death in hospital. The Patient Adviser and the family summarised the concerns and sent a letter of complaint to the NHS. The response from the NHS stated that there was a failure by a temporary nurse in relation to their father’s care. This will be addressed through the NHS Human Resource Policy. The response also advised that there are a number of actions that can be taken to address the failing. The NHS apologised for the loss of the family’s father and the failings identified and gave reassurance that the matter would be dealt with.
In the cases provided here, the clients have been aware that something has gone wrong, and so put in a complaint. For those who have not been aware, for whatever reason, that there has been an unintended or unexpected incident during their treatment, CAS would welcome the introduction of a duty of candour, and in particular the implementation of consistent responses.

Introducing a duty of candour would be in line with the Patient Charter which states that patients have the right to be informed, and involved, in decisions about their care and treatment, the right to be treated with dignity and respect and the right to have a say about their care. These are all particularly pertinent where someone may have been affected by an unintended or unexpected incident.

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

CAS would welcome the inclusion, in section 22, of a reference to organisations that can provide support to those being informed of an unintended or unexpected incident, for example, the Patient Advice and Support Service delivered by citizens advice bureaux and local advocacy organisations. Similarly, CAS would also welcome reference being made to the Scottish Public Service Ombudsman “our guidance on apology” in the accompanying documentation.

CAS would also request that training be provided to staff so that information can be provided thoughtfully in a way that is helpful rather than harmful or upsetting to patients when they are informed of an event which they may have no prior knowledge of. It would also be necessary for NHS to have clear definitions as to when a duty of candour would apply.

Citizens Advice Scotland (CAS), our 61 member Citizen Advice Bureaux (CAB), the Citizen Advice consumer service, and the Extra Help Unit, form Scotland’s largest independent advice network. Advice provided by our service is free, independent, confidential, impartial and available to everyone.

We are champions for both citizens and consumers and in 2013/14 the Citizens Advice Service in Scotland helped over 330,000 clients in Scotland deal with over one million issues overall. In addition, the Scottish zone of our self-help website Adviceguide which provides information on rights receives approximately 4.2 million unique page views annually.

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