The Scottish Centre for Children with Motor Impairments

Duty of Candour Implementation

November 2018

1. Introduction

The Scottish Government has introduced a new Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2018, which introduces a statutory Duty of Candour on health, care and social work services, including the day care of children (Nursery) services (which includes the SCCMI), with the duty coming into effect on April 1st 2018.

2. Background and Context

The stated purposes of the duty are to ensure that organisations are open, honest and supportive when there is an unexpected or unintended incident resulting in death or harm (outcomes), as defined in the Act, with such outcomes including:

(a) the death of a person;
(b) the permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (including removal of the wrong limb or organ or brain damage) ("severe harm");
(c) harm which is not severe, but which results in;
- an increase in the person's treatment,
- changes to the structure of the person's body,
- the shortening of the life expectancy of the person,
- an impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days,
- the person experiencing pain or psychological harm which has been or is likely to be, experienced by the person for a continuous period of at least 28 days,

(d) the person requiring treatment by a registered health professional in order to prevent:
- the death of the person, or
- any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned in (b) or (c)

The organisation responsible for monitoring compliance with the Act for day care services is the Care Inspectorate, working in partnership with Scottish Government, Healthcare Improvement Scotland, SSSC and NES, to design and develop education, training and monitoring requirements to enable organisations to meet the duty.

Substantial guidance documentation was published in April, and in addition a staff training resource provided, with such training required to be reported upon in an annual statement (see section 3.2).

3. Organisational Requirements

3.1 Duty of Candour Procedures

The duty requires organisations to follow procedures which include notifying the person affected, apologising[1] and offering a meeting to give an account of what happened. The procedures also require the organisation to review each incident and offer support to those affected. An incident which would activate the duty of candour procedure is defined as:

(a) an unexpected or unintended incident which has occurred in the provision of a health service, care service or a social work service to the person; and
(b) in the reasonable opinion of a registered health professional[2], the;

[1] An apology is defined in section 23 of the Act as 'a statement of sorrow or regret in respect of the unintended or unexpected incident'. An apology or other step taken in accordance with the duty of candour procedure under section 22 does not in itself amount to an admission of negligence or a breach of a statutory duty.

[2] The registered health professional who gives the opinion should not be involved in the incident. This means that the final decision by the organisation about whether to activate the duty of candour procedure for a particular incident will be informed by the views of a health professional who has not been personally involved, but could work for the organisation. In the SCCMI, the registered health professionals include: Professional Lead for Health; physiotherapists; occupational therapists; speech and language therapists.

- incident appears to have resulted in, or could result in an outcome mentioned above, and
- outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition.

The responsible person[3] must ensure that the registered health professional who gives the opinion following an incident is not an individual who was involved in the incident. (Defined in Annexe C)

The procedures are detailed in Appendix I with further detailed information available online.

3.2 Annual Report

Commencing in April 2019, for care services, annual return procedures require services to publish an annual report, with templates provided in guidance documents, published on the organisation's website, passed to the Care Inspectorate and must set out the elements identified.

- Information regarding the number and nature of incidents to which the duty is applied in relation to the service provided by the responsible person.
- An assessment of the extent to which the responsible person carried out the duty.
- Information related to the responsible person's policies and procedures as a result of incidents to which the duty has applied.
- Information related to any changes to the responsible person's policies and procedures as a result of incidents to which the duty has applied.
- Such other information as the responsible person thinks fit.

Even if there are no incidents, a report still requires to be published which details staff training elements undertaken during the preceding year. In addition, duty of candour reports will be examined as part of the Care Inspectorate's overall scrutiny of care services.

[3] A 'responsible person' is defined as a person (other than an individual) who provides a care service and in the SCCMI's context would be the Chief Executive.

APPENDIX I – Duty of Candour Procedures

View of the Registered Health Professional

A registered health professional must give their view on the incident and its relationship to the occurrence of death or harm and pre-existing illnesses or underlying conditions. Organisations must ensure that the registered health professional who gives the opinion mentioned above, following an unintended or unexpected incident, is not someone who was involved in the incident. This means that the final decision by the organisation about whether to activate the duty of candour procedure for a particular incident will be informed by the views of a health professional who has not been personally involved, but could work for the organisation. The legislation does not require this to be a detailed and comprehensive analysis of the incident to form an opinion about contributory factors. The requirement is for someone not involved in the incident to provide a view to inform a decision about activating the duty of candour procedure (which includes a review process).

Although it will be for the organisations to determine the most appropriate way of obtaining the views of the registered health professional not involved in the incident, it is likely that health professionals will require organisations to provide them with the following core information in the first instance:

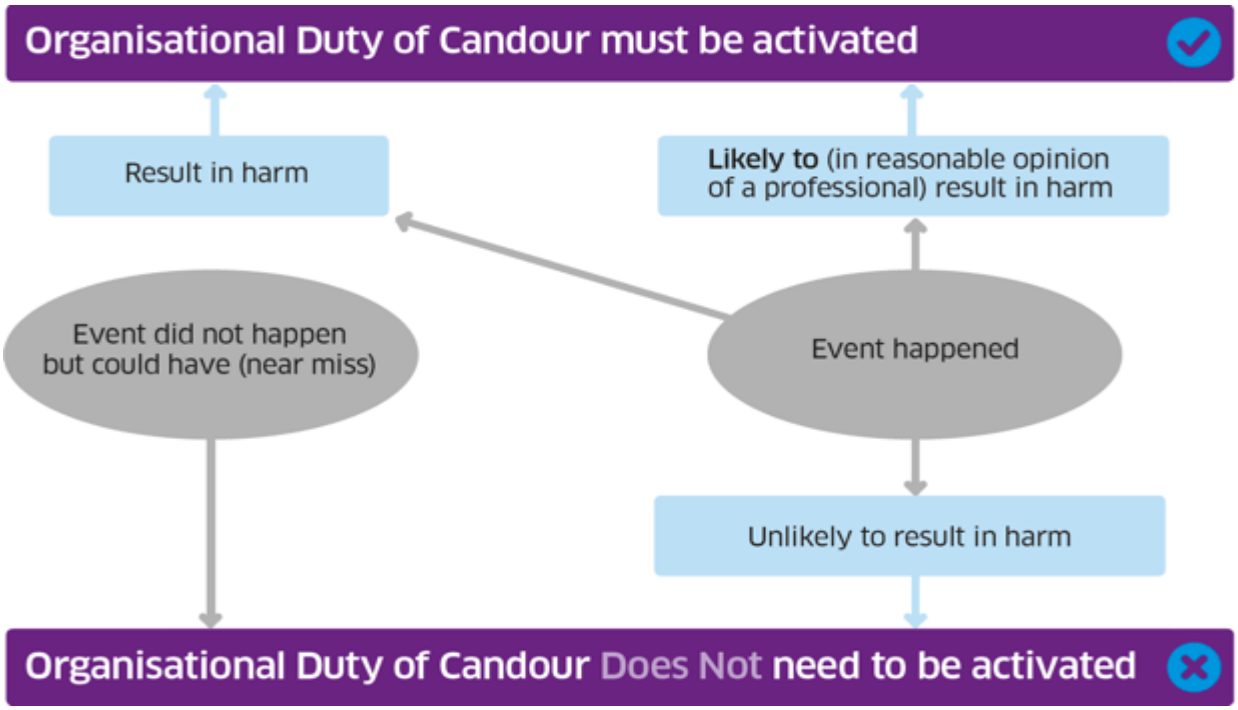
- What was the incident?
- What was the outcome?
- What illnesses and underlying condition did/does the person have?

The view of the registered health professional submitted to the responsible person should cover the following:

- Based on the background information provided, does it appear that this incident resulted in or could result in the death or harm described?
- Does the natural course of the person's illness or underlying condition directly relate to the death or harm described?

What does 'could result' mean and how is that decision to be made?

If the registered health professional thinks it is unlikely that harm will occur, then the duty of candour procedure need not be activated for that incident. The diagram below sets out the decision making process in more detail.



What is the procedure start date?

The procedure start date is the date that the organisation receives confirmation from a registered health professional that, in their reasonable opinion, an unintended or unexpected incident appears to have resulted in, or could result in an outcome listed above and that relates directly to the incident rather than to the natural course of the relevant person's illness or underlying condition.

Notification

Duty of Candour legislation states that the relevant person should be notified as soon as reasonably practicable but it should be considered good practice to notify the relevant person within 10 working days of the procedure start date. This notification can be by various methods including telephone, face to face or by letter. It is important to remember that where a duty of candour procedure start date is more than a month after the incident, the organisation must provide the relevant person with an explanation of why this is.

Things to consider

Before having the conversation at the point of notification, the organisation may wish to consider:

- Who from the organisation is already in contact with the relevant person?
- What discussions or information exchange has already taken place?
- What is the relevant person's current understanding of the incident and organisational response to this?
- Where the conversation takes place?
- Who should be part of, and who should lead that conversation?
- What support should be available to the relevant person during the conversation and afterwards?
- Who will be the single point of contact following the discussion with the relevant person?

The notification must include:

- an account of the incident to the extent that the organisation is aware of the facts at the date the notification is provided; and
- an explanation of the actions that the organisation will take as part of the procedure;
- In the case where the procedure start date is later than one month after the date on which the incident occurred, an explanation of the reason for the delay in starting the procedure.

Things to consider

Information an organisation may need to consider in deciding whether to activate the duty of candour procedure can come from a range of sources. It will be important for organisations to identify what these sources are and ensure relevant information, support and co-ordination mechanisms are in place. In some instances organisations may be contacted by other organisations providing health, care or social work services when it appears that the activation of the duty of candour procedure should be considered. Organisations should ensure that staff are aware of how to deal with such scenarios. Organisations should consider the support needs of relevant persons at the earliest possible opportunity and while following the duty of candour procedure.

Communication with a Relevant Person

Organisations must take reasonable steps to find out the relevant person's preferred method of communication. They must also take reasonable steps to ensure that communication with the relevant person is in a manner that they can understand.

Things to consider

Thinking about communication with the relevant person.

- Do you have any knowledge currently about their preferred method of communication? It is recognised that in some instances communication channels may not exist or preferences are unknown. Establishing contact by telephone in the first instance might be necessary to find out what method of communication to use, and to begin dialogue on what steps might need to be taken in following the duty of candour procedure.
- If an organisation is unable to contact the relevant person or the relevant person does not wish to speak with a representative of the organisation, the attempts made to contact them need to be included as part of the organisation's written record of following the duty of candour procedure.
- Organisations need not provide information if a relevant persons indicates they do not wish to receive it.

- The Regulations do not permit or require organisations to disclose any information that would prejudice any criminal investigation or prosecution or contravene any restriction on disclosure arising by virtue of an enactment or rule of law.
- Organisations need to be mindful of their obligations to act in accordance with the European Convention of Human Rights, and any other relevant laws relating to personal information.

What are the implications if a claim for compensation is made once the decision to follow the duty of candour procedure is made?

While it would not be appropriate for an organisation to try to prevent the relevant person from making a claim, organisations can suggest to relevant persons that they may wish to wait until the duty of candour procedure has concluded, when their case will have been investigated; they will have received an apology; the facts will have been established and any actions to improve the quality of care and/or learning will have been identified.

If a relevant person mentions that they are considering making a claim, the duty of candour procedure should continue. If a relevant person makes a claim (i.e., the organisation receives formal notification of commencement of legal proceedings), then some elements of the duty of candour procedure may need to be paused until the legal process reaches a conclusion. For example, internal reviews could still proceed and organisations should still try to identify any potential improvement and learning actions.

Apology

In addition to any apology provided at the time of the incident, as part of the duty of candour procedure the organisation must offer the relevant person a written apology (this can be by electronic communication if that is the relevant person's preferred means of communication) in respect of the incident. The organisation must provide a written apology if the relevant person wishes it. The written apology should be personal and be provided at an appropriate time during the duty of candour procedure, taking account of the facts and circumstances in relation to the particular incident. This should take account of the circumstances relating to the relevant person and, wherever possible, the known personal meaning or impact of the unexpected or unintended incident.

There may be misconceptions and misunderstanding that the provision of an apology equates to an admission of liability and that organisations should never offer apologies for this reason – but that is not correct. Section 23(1) of the Act states that "an 'apology' means a statement of sorrow or regret in respect of the unintended or unexpected incident." The Act sets out that 'an apology' or other step taken in accordance with the duty of candour procedure does not of itself amount to an admission of negligence or a breach of a statutory duty."

Meeting

The organisation must invite the relevant person to attend a meeting and give them the opportunity to ask questions in advance. The organisation must take reasonable steps to ensure that the meeting is accessible to the relevant person, having regard to their needs. For example, linguistic needs or reasonable adjustments that might need to be made for someone who has a disability. In some circumstances it will be necessary to have an interpreter, an advocate and/or someone the relevant person chooses to support them present.

<u>Things to consider</u>
- A quiet room should be used, free from distraction and where the meeting will not be interrupted. It may not be appropriate to host the meeting close to where the incident happened as this could be emotionally difficult for the relevant person.
- At the meeting, the organisation's representative should speak to the relevant person in the same way as they would want someone in the same situation to communicate with them or a member of their own family.
- Staff should try to avoid the use of jargon or explain technical terms when speaking with relevant persons.

The meeting must include:
- a verbal account of the incident;
- an explanation of any further steps that will be taken by the organisation to investigate the circumstances which it considers led or contributed to the incident;

- an opportunity for the relevant person to ask questions about the incident;
- an opportunity for the relevant person to express their views about the incident; and
- the provision of information to the relevant person about any legal, regulatory or review procedures that are being followed in respect of the incident in addition to the procedure.

Following some unexpected or unintended incidents there may be several review processes operating in parallel. This can be confusing for people. To try to lessen this confusion, meetings with relevant persons must include details of other procedures which are being followed including their differing scope and focus.

In circumstances where an organisation is concerned, for example, that an unintended or unexpected incident was contributed to by factors influencing the capability of an employee it may be helpful for the relevant person to know that in addition to the systems review that is in operation, a separate process has been put in place to identify whether an employee may benefit from support and/or consider matters not related to organisational review and learning.

After the meeting the relevant person must be provided with:
- a note of the meeting;
- contact details of an individual member of staff acting on behalf of the organisation who the relevant person may contact in respect of the procedure.

Things to consider
- Make sure the organisation agrees with the relevant person what the note of the meeting will include. This does not need to be a verbatim account of the discussion but could include when and where the meeting took place, a record of the apology and actions and timescales that were agreed.
- Make sure that this note of the meeting is shared in good time with the relevant person. In some instances where the note of the meeting is brief, it may then be followed by a more comprehensive summary of the issues covered in the meeting – for example, outlining the questions that were asked or views expressed and the matters discussed. The note of the meeting may include reference to the process for producing this.
- If the relevant person does not wish to, or is unable to attend the meeting, the organisation must still provide them with the information set out above (other than a note of the meeting) if the relevant person wishes it.

The Review

Organisations must carry out a review of the circumstances which they consider led or contributed to the unintended or unexpected incident. The legislation does not specify the manner in which the review is undertaken, but it is likely that this will be one of a range of review processes that are already undertaken such as an adverse event review, a significant case review of the sort undertaken by child, adult and public protection committees or a morbidity and mortality review. Best practice requires that reviews involve clinical and care professionals with the relevant subject matter expertise, as appropriate.

Best practice in reviewing unintended or unexpected incidents that have resulted in death or harm require that a systems emphasis is adopted. This is clearly illustrated in resources such as the Systems Analysis of Clinical Incidents (known as The London Protocol) and the Social Care Institute of Excellence's Learning Together model. It is the emphasis on contributory factors in this and similar protocols that represent best practice features of the reviews that must be conducted. Organisations may find the NHS Improvement Just Culture Guide a helpful resource for framing their approach to reviews.

In the case where the review is not completed within three months of the procedure start date, the organisation must provide the relevant person with an explanation of the reason for the delay in completing the review.

In carrying out the review, organisations must seek the views of the relevant person and take account of any views expressed. This will be best implemented through the development of a supportive relationship with the relevant person and arrangements that ensure review processes consider the views of the relevant person and are able to demonstrate the way in which these views (which are likely to reflect what matters most) have been taken account of.

Organisations must prepare a written report of the review, which must include:
- a description of the manner in which the review was carried out;

- a statement of any actions to be taken by the organisation for the purpose of improving the quality of service it provides and sharing learning with other persons or organisations in order to support continuous improvement in the quality of health, care or social work services; and
- a list of the actions taken for the purpose of the procedure in respect of the incident and the date each action took place.

This provides organisations with an opportunity to demonstrate that the views of relevant persons have been considered and that a review has been conducted that has focused on systems analysis that takes account of best practice in review and investigation of human factors.

The legal requirement to include details of the dates when each element of the duty of candour procedure took place is included to provide an overview of the process within an organisation from the point that they decide to activate the duty of candour procedure to the point the review is concluded. Where possible, written reports should be written in a manner that minimises the need for extensive redaction.

Organisations must offer to send the relevant person:
- a copy of the written report of the review;
- details of any further information about actions taken for the purpose of improving the quality of service provided by the organisation or other health, care or social work services; and
- details of any services or support which may be able to provide assistance or support the relevant person, taking into account their needs.

Things to consider
- It should not contain jargon or acronyms which are difficult to understand. It should be clear and understandable.
- Review reports should include information on the actions that are to be taken to make improvements in systems and processes influencing the quality of care delivery. The actions taken to share learning with other organisations (such as those who might have similar organisational processes to the ones that formed the basis of the review) should be outlined in the written review report.
- The inclusion of the term 'further information' in the legislation recognises that supporting information to explain the conclusions of a review or provide details to explain why it is thought a particular action will improve quality can often be very helpful in demonstrating the approach to improvement implementation that will be adopted.

Records

Organisations must keep a written record for each incident to which the duty of candour procedure is applied, including a copy of every document or piece of correspondence relating to the application of the duty of candour procedure to the incident. The written record should be retained by the organisation in accordance with relevant local policies and procedures.

Reporting and Monitoring

The responsible person must prepare an annual report, as soon as reasonably practicable after the end of that financial year. The report must include:
- information about the number and nature of incidents to which the duty of candour procedure has applied in relation to a health service, a care service or a social work service provided by the responsible person;
- an assessment of the extent to which the responsible person carried out the duty of candour;
- information about the responsible person's policies and procedures in relation to the duty of candour, including information about procedures for identifying and reporting incidents, and support available to staff and to persons affected by incidents;
- information about any changes to the responsible person's policies and procedures as a result of incidents to which the duty of candour has applied;
- such other information as the responsible person thinks fit.

The report must not mention the name of any individual, or contain any information that could identify any individual. The report must be published in a manner that is publicly accessible. For instance, on an organisation's website.

When the SCCMI has published a report, they must notify:

- The Care Inspectorate, in the case of a report published by an organisation which provides a care service or a social work service. **The Care Inspectorate will ask for information about whether or not care services have published their duty of candour report in the first set of Annual Returns following the end of the financial year after which the report must be published.**