Scottish Public Services Ombudsman response to the Professional Standards Authority for Health and Social Care Questionnaire on Duty of Candour

Background

1. The Scottish Public Services Ombudsman (SPSO) is the final stage for complaints about councils, the National Health Service, housing associations, colleges and universities, prisons, most water providers, the Scottish Government and its agencies and departments and most Scottish authorities.

2. When considering health and social work complaints, we have an extended jurisdiction and can look directly at the quality of professional decision-making.

3. We also have a role in setting standards for complaints. We worked with NHS Scotland, the Scottish Government and other stakeholders to develop the NHS Scotland Complaints Handling Procedure (which came into force on 1 April 2017) taking a partnership approach.

4. The Scottish Government announced in November 2017 that they intended to give the Ombudsman the additional function as the Independent National Whistleblowing Officer for Scotland. SPSO is currently working (in partnership) to prepare Principles and Standards for this new function.

Questions

1. Do you think there has been a change in professionals' attitudes to candour since 2014? (the regulators' joint statement was published in 2014) If so, how?

The organisations about which SPSO receives complaints and which are listed in our legislation are the NHS Boards, or family health service providers.

We look at the care provided by individuals working for the Board or service provider when investigating complaints. We can assess professional behaviour and judgement, but we do not assess directly or in a quantitative way the candour of individual professional unless part of an individual complaint. This means the evidence we have is indirect and qualitative, based on our investigations of the individual experience of patients and their familes, but we consider it is still possible to provide some evidence from this about the general culture of candour within the Scottish NHS (SNHS).

We have seen examples of good practice (and have at times, praised clinicians for their candour). However, we continue to see issues which suggest that the supportive culture needed to enable effective application of the professional duty of candour is not consistent across the SNHS. Our observation is that professionals operate within the broader culture of their Board, hospital ward, or GP practice rather than within a culture supportive of candour at an individual level. Feedback received when preparing for the proposed new INWO role is that when professional duties, (in that context, the duty to report concerns) conflict with the broader culture, steps taken by professionals to meet those duties may meet with a lack of understanding, negativity or resentment.

New Scottish legislation which came into force on 1 April 2018 seeks to address the broader culture by placing duties on organisations and significant work has been undertaken in the past year to support this and to share best practice. The aim of the new organisational duty of candour provisions is to support the implementation of consistent responses across health and social care providers when there has been an unexpected event or incident that has resulted in death or harm that is not related to the course of the condition for which the person is receiving care. While it is too early at this date to say whether this will be successful in ensuring greater consistency of approach, the positive work in Scotland to highlight the importance of candour should be noted.

2. In your experience, what problems have been highlighted to you about the candour of professionals?

Communication remains at the heart of many of the complaints we receive and some of the service failings we see indicate issues with candour either at an individual or organisation level. The first step to being able to meet a duty of candour is the ability to identify failings and, too often, we are publishing reports of investigations when we have found failings that should (and could) have been identified earlier.

In this report, for example: https://www.spso.org.uk/investigation-reports/2017/december/lanarkshire-nhs-board we highlighted that there were three different occassions when an error made could have been identified before the complaint reached us.

This report contains another example of a falure to identify and therefore investigate potentially serious errors: https://www.spso.org.uk/investigation-reports/2017/april/highland-nhs-board[1]

We have also noticed that when failings are accepted, there can be delays in notifying patients or their families[2] which affect the confidence they have in the information they are being given. We have also seen examples where failings were appropriately identified but that the step to ensure learning occurred did not happen and was not shared with the family[3].

3. From your perspective, are you aware of any barriers to professionals behaving candidly?

We highlighted in our response to the first question the impact of culture. If the culture of an organisation is defensive staff can be fearful about making admissions because they will be criticised or judged by their employers and colleagues.

To give some examples, in this report we highlighted how defensive the Board was to criticism: https://www.spso.org.uk/investigation-reports/2018/january/greater-glasgow-and-clyde-nhs-board Similarly, we have had sight of letters where Boards have downplayed the comments of professionals made to patients and their families by suggesting these were either not accurate or that they need to be seen in context. This approach is not likely to encourage the professionals involved to continue to be open with patients.

[1] And see also these other recent reports: https://www.spso.org.uk/investigation-reports/2018/april/lanarkshire-nhs-board and https://www.spso.org.uk/investigation-reports/2017/august/orkney-nhs-board
[2] See this report https://www.spso.org.uk/decision-reports/2018/january/decision-report-201609720-201609720
[3] See this report for a good example of this: https://www.spso.org.uk/decision-reports/2018/april/decision-report-201607810-201607810

There also needs to be trust between professionals to allow them to deal with situations where individual professionals disagree about the quality of care and whether there was a failing. In this report we found an example of a breakdown in communication between a professional and a Board which led to significant delays in responding to the complaint because they could not agree on what had happened; consequently the issue was never resolved: https://www.spso.org.uk/decision-reports/2018/january/decision-report-201609754-201609754

We also find when meeting professionals directly that there remains confusion about what it means to admit to failings and whether they are risking admitting to legal liability and, at times, genuine fear about what an admission may mean for themselves, their organisation and their colleagues.

3. How can professionals be influenced to behave candidly?

Our impression from complaints handling is profesionals working within SNHS are loyal to the SNHS and their colleagues and wish to do the best possible for patients and their families. We understand they can feel overwhelmed by the expectations placed on them, particularly when demand is high and resources are limited. We would suggest the question should not be how should they be influenced to behave candidly but how can they be supported to behave candidly. In December 2017 we published a report: Making Complaints Work for Everyone[4] where we set out the critical importance of supporting staff to the development of a genuine learning culture.

4. How does your organisation encourage professionals to behave candidly (if at all)?

In our role as the Complaints Standards Authority, we provide support, training materials and publish specific guidance to encourage an open and honest approach to complaint handling[5]. One of our most successful and popular pieces of guidance is our guidance on making an apology: https://www.spso.org.uk/sites/spso/files/communications_material/leaflets_buj/Apology%20for%20Web%20170914.pdf.

We anticipate that as our role as the Independent National Whistleblowing Officer develops, we will be working in a way that supports the development of a culture that values openness and transparency, and demonstrates to both staff and patients how they identify concerns and use them to improve services.

5. What role do professional regulators have in encouraging candour among their registrants?

While we engage with regulators, we do not consider we have enough evidence to respond directly to this and the following questions.

6. If regulators have a role in encouraging candour, have professional regulators been successful in carrying out this task?

7. Can professional regulators do more to encourage candour? If so, what?

[4] http://www.valuingcomplaints.org.uk/sites/valuingcomplaints/files/resources/MakingComplaintsWorkForEveryoneFinalWeb.pdf
[5] More details of the extensive work we do in this area can be found in our annual reports: https://www.spso.org.uk/annual-reports or on our valuing complaints website: www.valuingcomplaints.org.uk

8. Are there any general comments, feedback, observations you wish to make?

Providing health and social care services necessarily carries a risk that, on rare occasions unintended or unexpected events may result in death or harm. It is important that when such unintended events happen, professionals are empowered and confident to communicate quickly and honestly to explain what went wrong (if anything) and what has been learned to prevent recurrence. For this to happen effectively, all professionals need support and training. Learning from such disclosures must drive improvement and support the development of a learning culture across the organisation.