Annex B
CONSULTATION QUESTIONNAIRE

Question 1 :
Do you agree that the arrangements that should be in place to support an organisational duty of candour should be outlined in legislation?

Yes x☐ No ☐

East Lothian and Midlothian Public Protection Committee welcome the focus on transparency as reflected in the organisational duty of candour. It is felt that our constituent organisations currently uphold the principles of openness and transparency and this will both strengthen and give a formal framework to achieve this.

Question 2:
Do you agree that the organisational duty of candour encompass the requirement that adequate provision be in place to ensure that staff have the support, knowledge and skill required ?

Yes x☐ No ☐

The barriers and inhibitors to disclosure are recognised and staff training will be crucial to address important cultural issues and advanced communication skills which would facilitate confidence in the ability of staff at all levels to be open and transparent. We would welcome multi-agency training to facilitate consistency in approach across all our organisations.

This will require resources both to develop policies and procedures and to release staff for training.

Question 3a: Do you agree with the requirement for organisations to publically report on disclosures that have taken place ?

Yes x ☐ No ☐

More information is required with regard to what information would be made publicly available – i.e just the number of disclosures, or more detailed information. There is some anxiety around publishing more detailed information as there may be the potential for people to be identifiable thus constituting a data breach. For this reason we are suggesting that reporting should be on an annual basis.

It is felt that Scottish Government should prescribe reporting procedures and these need to ensure that there is no duplication in reporting. It should be noted that some information is already available for the public via Regulatory Body inspection reports, Chief Social Work Officer Reports and Freedom of Information requests.

Question 3b: Do you agree with the proposed requirements to ensure that people harmed are informed ?

Yes x ☐ No ☐

We would always start from the premise that the person, or their proxy, has a right to know, so agree in principle with this requirement. However, such a requirement needs to address what should happen for people who have cognitive impairment, and the impact such information may have on them.

Clear guidance is required as to the threshold when a disclosure of harm should be made.

Question 3c: Do you agree with the proposed requirements to ensure that people are appropriately supported ?

Yes x ☐ No ☐

It was felt crucial that individuals, families and staff are appropriately supported throughout the process, however this has the potential to be very resource intensive in a time of pressure on resources in all organisations.

We note that guidance will be produced by Scottish Government and welcome the fact that resources will be included to support the process.

Question 4:
What do you think is an appropriate frequency for such reporting ?

Quarterly ☐ Bi-Annually ☐ **Annually x** ☐ Other ☐ (outline below)

As stated in 3a to mitigate the risk of people being identifiable.

Question 5:
What staffing and resources that would be required to support effective arrangements for the disclose of instances of harm ?

It is noted that intention is that notifications should be made in person to the relevant person and currently this would fit with the expectation that frontline staff working with individuals would talk to them about incidents which may have happened, and the delicate balance we often negotiate between harm and protection. It may be, however, that it needs to be a more senior person in the organisation.

It is hoped that clear guidance will be given by Scottish Government which will clarify expected procedures around the organisational duty of candour, and identify the most appropriate people to train to undertake such duties.

The expectation is that training will be provided for staff at different levels in organisations.

Question 6a:
Do you agree with the disclosable events that are proposed ?

Yes x☐ No ☐

Comments
In principle, however, the disclosable events cover a very broad range of circumstances and it is recognised that in our organisations there are frequently conflicting pressures such as delayed discharge; where other pieces of legislation come into play. Another area of potential conflict is Self Directed Support where our organisations are required to take a considered risk enablement approach which may result in unintentional harm.

Also it is recognised that working in statutory settings where we are required to implement compulsory measures to keep people safe, there may be situations which are perceived as harmful by individuals involved. For example decisions around a child being accommodated, separated from siblings or left in the care of a chaotic household may have perceived unintended harmful consequences in later life.

Clarity is required on these situations from Scottish Government.

Organisations will need to ensure defensible decisions are accurately recorded by staff involved.

Question 6b: Will the disclosable events that are proposed be clearly applicable and identifiable in all care settings ?

Yes ☐ No x ☐

Comments

Across our organisations we work in extremely complex situations involving several different statutory organisations – guidance should clarify in such circumstances, which organisation holds the duty of candour. For example for a delayed discharge it could be either NHS or the Local Authority. Similarly for childrens' services a lack of resource might mean that siblings are separated within a foster care setting.

Question 6c:
What definition should be used for 'disclosable events' in the context of children's social care?

Comments
It was felt that this should have as similar approach to adult services as possible, to ensure consistency, however there was some anxiety about this due to differing priorities and pressures at different ages and stages in a child's life. It is recognised that accommodating a child with the best of intentions at a young age may have unintended harmful consequences in later life, but it is difficult to see the benefit of this being a disclosable event. Clarity is required as to what should be included / excluded.

Question 7
What are the main issues that need to be addressed to support effective mechanisms to determine if an instance of disclosable harm has occurred ?

It is recognised that harm is experienced on an individual basis, as what may be experienced as harmful for one person may not be for another. Instances of physical harm would be clearer to identify than instances of psychological harm.

A clear definition of harm is required which needs to be consistent with other existing legislation - the Adult Support and Protection (Scotland) Act 2007, Adults With Incapacity (Scotland) Act 2000, Mental Health(Care and Treatment)(Scotland) Act 2003, Scottish Government National Guidance for Child Protection (2014) Risk Management Authority (Criminal Justice(Scotland) Act 2003). Getting it Right for Every Child, Children & Young People (Scotland) Act 2014.

Guidance on how you determine whether someone has been harmed or not to enable a consistent approach across organisations is necessary. In all of the above mentioned legislation/guidance there are variations with regards

to thresholds, with some speaking of significant harm, and some serious harm but no clear definition or guidance as to what the thresholds for either of these are.

Training in all of these aspects as well as advanced communication skills is required.

Question 8:
How do you think the organisational duty of candour should be monitored ?

Comments

From within existing local regulatory structures, with a plea for avoidance of double reporting.

Question 9:
What should the consequences be if it is discovered that a disclosable event has not been disclosed to the relevant person ?

Comments

It was felt that current investigatory / reviewing procedures should be utilised and it was felt important that a consistent systematic approach should be undertaken with the focus on learning and not on blame.

This fits with current reviewing processes already in place such as those for Significant Case Reviews / Significant Incident Reports and the role which the Care Inspectorate has in these, and Significant Case Reviews for MAPPA cases.

End of Questionnaire