

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 No

The need for openness and transparency when things go wrong has been identified in a number of high profile cases and subsequent reports such as the Frances Report. It has a strong evidence base in driving quality improvement, patient safety and promotes public confidence. Whilst the evidence base is within Healthcare we believe it to be transferable to Social Care underpinning integration. It also underpins the values of the many clinical and Social Work professions.

A statutory requirement will ensure all organisations involved in the delivery of care and treatment embed the principle of candour in day to day activities increasing public confidence in Services wherever they may be delivered.

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 No

Known barriers to disclosure are fear, lack of confidence in communication skills and fears that people will be upset. The provision of support, knowledge and skills development in this area of practise will be essential.

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

Yes No

Demonstrates a commitment to openness, transparency, accountability and improvement. Non-disclosure would be at odds with a duty of candour.

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

Yes No

It is essential that a clear definition of harm is utilised across Scotland supporting consistency of approach. It should make provision where disclosure is foreseen to cause greater harm to an individual. Withholding of information should be the exception. Such cases should be subject to external scrutiny and should not contravene human rights. Where issues of capacity arise information should be shared with guardian or individual's representative.

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

Yes No

The needs of the individual should be considered prior to and during disclosure ensuring appropriate support is provided to meet their needs. Consideration should be given to the role of advocacy services within the proposal.

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

Quarterly Bi-Annually Annually Other (outline below)

At least annually to the NHS Board, Integration Board and relevant Committees of Social Work and Health. In the case of Children the Child Protection Committee and relevant multi-agency Childrens Services Committees.

It should form part of NHS Boards and Local Authorities annual report and be included in the annual review framework for the NHS undertaken by Scottish Ministers.

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

It is difficult to quantify resource requirements. This will be dependent on the definition of Harm. If focused on very serious circumstances it is likely that Senior Managers and Clinicians would lead and would have the skills and competencies. If the definition is widened it is likely to include: Staff development, increased capacity and further development of the complaints and risk management processes.

Regardless of the definition of Harm there will be a need to devise policy and to give internal consideration to publicising the new duty and its resourcing implications.

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

Yes No

Disclosable events are currently ill defined within the document. Greater specificity is required ensuring serious harm is disclosed reducing the potential for tenuous links being made with unrelated policies and organisational priorities.

9.5 Good practice would be to inform individuals of national media interest.

9.12 Prolonged episodes of care or cancellation of treatment may not result in harm. Only when harm occurs should it be subject to the statutory duty

9.15 Further clarity is required ensuring NHS Boards and Local Authorities are clear where disclosure is required. The area of Adult Support and Protection should be included.

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

Yes No

- Further clarity is required regarding 9.12 and 9.15.
- Some events are specific to particular Specialties such as Child Protection whilst others could be generically applied.
- Statutory duty of candour should apply to all sectors such as the third Sector and included in all contractual arrangements.

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

- Services being slow to react resulting in a child's exposure to chronic neglect being prolonged.
- Undue delays in permanency planning and completion arising from practice and or resourcing decisions.
- Incomplete implementation of a child's plan resulting in serious harm.

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?

Issues include:

- Common and clear definition
- Organisational policy detailing roles, responsibilities and accountability from the Board Room to the frontline
- Practice and performance overseen via the Governance Committees of the NHS Board and Local Authority
- Staff development and support at all levels of the organisation ensuring disclosable issues are identified
- Capacity of Senior Clinical Leaders to determine a disclosable incident has occurred and to ensure disclosure occurs.

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

Monitoring should occur via the current performance management and scrutiny arrangements and include notification to Health Improvement Scotland and the Care Inspectorate.

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

In the first instance it should be treated as a learning opportunity with organisations being required to inform the individual and regulators such as the Mental Welfare Commission where appropriate of their failure to disclose and reasons. An improvement plan should be developed and implemented to prevent recurrence. The organisations Human Resource Policies should be utilised where required.

Further non-disclosure should result in organisations being fined. The size of the fine should be on a sliding scale reflecting the scale of non-compliance identified.

End of Questionnaire