

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

This question presupposes that we agree that it is necessary to introduce an organisational duty of candour in Scotland as proposed. We recognise and accept that the proposal has been prompted by nationally reported situations which have occurred in NHS and independent hospitals, but from a Scottish social work and social care perspective there are robust reporting and monitoring arrangements already in existence which deserve to be given particular consideration in the drafting of any legislation.

As referenced in 4.9 and 4.10 of the consultation paper, there are existing requirements on registered care providers to report the death or other adverse event affecting a person who was receiving services from them to the Care Inspectorate, as well as to report an adult at risk of harm to the local authority under the Adult Support and Protection (Scotland) Act 2007. Contrary to the assertion within paragraph 4.10, the requirement to report all incidents involving adults at risk of harm to the local authority is specified within existing legislation, being the 2007 Act, and it should be noted that this duty also applies to NHS and independent hospital services regulated by Healthcare Improvement Scotland. Additionally and where appropriate, the provider should advise the service user's family about any such incidents, and information on complaints about the service is recorded on the Care Inspectorate's website. More serious incidents occurring in relation to the care provided by registered services require a review of not only the affected service user's care, but also the care of all other service users in conjunction with each service user and/or their family. These existing arrangements require disclosure of a greater range of events to the service user/their family and regulatory/investigatory agencies than is proposed at 9.14. No arguments are advanced as to why a statutory duty of candour must be applied to registered services in addition to these existing requirements and arrangements or what benefit this unnecessary duplication will bring to people using such services and their families.

The consultation paper signally fails to take account of existing requirements to notify the Mental Welfare Commission about a variety of adverse events affecting individuals with a mental disorder or learning disability including deficiency in care or treatment which results in serious harm (<http://www.mwscot.org.uk/good-practice/notifying-the-commission/>). It provides no rationale for duplicating such requirements, or proposals as to how these may be otherwise incorporated into the general duty of candour as might apply to local authorities, health services or independent service providers.

In general, it is unclear to what extent the paper has taken Scotland's current social care legislative and regulatory framework into consideration in developing these proposals.

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

Organisational support systems are the key element here. Staff will experience emotional reactions themselves where a service user they are working with dies in unanticipated circumstances and this element of the duty would assist in ensuring appropriate arrangements are in place.

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

Yes No

As noted, there are already systems in place to support public reporting of harm in relation to social care services. Caution must be exercised about the amount of detail which is made public in respect of data protection considerations and protecting personal information.

Investigation and remedial action in respect of some notifiable incidents may take a considerable period of time to conclude, depending on the level and type of investigation involved.

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

Yes No

Much of what is proposed is already practiced within registered social care and professional social work services in line with existing legislative and registration requirements.

The proposals do offer an opportunity to go beyond informing the "relevant person" to promoting the involvement of the "relevant person" in reviewing disclosable events.

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

Yes No

Again, we would see this as intrinsic to the social work role, and part and parcel of adult support and protection practice.

Question 4:

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

Quarterly Bi-Annually Annually Other (outline below)

This may vary according to organisation. We think a formal report should be made annually, and within East Dunbartonshire envisage this would take the form of a report to the Social Work Committee.

Question 5:

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

It is not clear to us that current arrangements in respect of social care services are ineffective.

The duplication of existing reporting structures will require additional administrative support.

Question 6a:

Do you agree with the disclosable events that are proposed?

Yes No

We do not think the disclosable events listed at paragraphs 9.9 to 9.15 are consistently described and defined, particularly those relating to social care services at 9.14 and 9.15. The application of 9.14 may be appropriate to a serious harmful event affecting an older adult who lacks capacity and is receiving 24 hour care in a care or nursing home, but not to all adults accessing social care services.

The proposals as worded would suggest that if anyone who uses a social care service was, for example, injured in a car accident, this would be a disclosable incident, regardless of any connection between the type or provision of the service and the service user's accident. This carries with it a discriminatory implication that any person accessing a social care service must lack the capacity to judge and take informed risks about everyday activities. Disclosable events for social care providers must be related to harm which occurs within the direct context of the delivery (or non-delivery) of care, and this will vary according to the type(s) and amount of care which

the individual accesses.

Another issue with the proposals at 9.14 is that the term harm itself is used in an ill-defined way. The Adult Support and Protection (Scotland) Act 2007 already provides definitions of different types of harm which are applied in practice on a daily basis, apply to all health and care settings and include harm occurring within a service delivery context.

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

Yes No

There is an absolute need to distinguish between the disclosable events as proposed in distinct types of care settings. The position will be different for joint or integrated teams which provide a range of health and social care services, for example East Dunbartonshire's Alcohol and Drugs team.

The Mental Welfare Commission's existing notification guidance referred to under Q.1 provides a useful example of how disclosable events may be consistently defined in relation to care and treatment delivered in different settings. The use of the term "deficiency" is also very helpful.

Question 6c:

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

It is not clear to us why a distinction is to be made between adults' and children's social care services in terms of disclosable events.

In respect of the scenario proposed at paragraph 9.15, adults can be as vulnerable as children in terms of the unintended consequences of agency interventions to secure their safety and welfare. For example, if a protection order is granted to ban an adult son from having contact with his aging mother because his behaviour is putting her at risk of serious harm, this very lack of contact could cause her great distress i.e. prolonged psychological harm. Both scenarios have in common the role played by statutory social work services in respect of care and protection decisions, where no option is risk-free and all options require to be thoroughly assessed and regularly reviewed in conjunction with the service user, carers and partner agencies.

Specific consideration should be given as to what may be disclosable events for social work assessment and care management services as distinct from social care delivery services.

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?

Clear definitions and clearly understood thresholds are required if mechanisms are to be effective. It would be helpful if such definitions and mechanisms were consistent with those already in place, for example as identified by the Care Inspectorate and the Mental Welfare Commission, or associated with the 2007 Act. It would also be helpful if these existing, well understood arrangements were built upon and not duplicated, since we feel this would be bound to create confusion.

Question 8:

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

As above, existing requirements for social care providers to report and notify are monitored by relevant bodies such as the Care Inspectorate, local authority and Mental Welfare Commission.

Question 9:

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

Paragraph 6.2 outlines proposed action where there is a delay in disclosure. There are existing consequences and sanctions where regulated services fail to meet the relevant standards applying to them.

There is no definition of the term “relevant person” provided in the document. This will require to be developed as appropriate to Scotland’s existing legal and rights context and be capable of consistent application across all care settings.

End of Questionnaire