

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

We agree that as there still appears to be so many cultural and behavioural barriers to dealing with incidents and those who have been affected by them that new legislation does indeed seem necessary. However, this should promote a transparent approach across NHS Scotland. We expect that information sharing will be dealt with in the legislation to ensure that appropriate information sharing in these circumstances also becomes a duty both internally and externally. Some of the issues we envisage from an information governance view point include:

- The consistency in approach:
 - Cross agency incidents – Board, Local Authority and the new Joint Integration Boards involvement - a single system in use by all agencies would be the ideal.
 - Disparate systems means the only cross agency/area view would be from the centrally reported incidents and not at local Board, Local Authority and Joint Integration Boards level.
- The consistency in reporting to ensure that the disclosable events can be properly recorded.
 - The disclosable events descriptions in Chapter 3 look quite comprehensive.
- Access to healthcare/social care records:
 - Identification and reporting of incidents will result in 'independent' assessment of events - not by those involved in the event so information may have to be held in a separate environment.
 - Protection will have to be given to the data used in the process to avoid damage to the validity of process.
 - Privacy must be maintained throughout the process to protect the relevant person from further harm.

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

This will be crucial in supporting staff undertaking disclosure to be effective and well prepared.

This may require additional resources to support this and national training for key organisational leads.

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

Yes ✓ No

This will be a huge step forward but we need to be mindful of additional resources required to make this work, systems and people to ensure that we can monitor effectively and to make collation easy.

We also need to be mindful of the Data Protection Act and the Freedom of Information (Scotland) Act.

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

Yes ✓ No

The proposals support professional governance and accountability and the recently published joint statement by professional regulators in October 2014 about openness and honesty - the professional duty of candour.

In addition, within NHS Tayside Clinical Governance Strategy, November 2013 - 2016, the organisation has already made a commitment to demonstrate openness and honesty to patients, families, carers and members of the public and has communicated this in Value 4 of NHS Tayside Vision and Values;

Take the time to have good, open communications and be accountable for our actions and behaviours

The proposals support person centeredness and the Fair and Just Culture promoted by NHS Tayside Clinical Governance Strategy and therefore the proposals are an approach already being embedded within NHS Tayside organisational culture and, within the auspices of principles for professional governance, should be encouraged.

We may however have to strengthen our policy to support this.

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

Yes ✓ No

This again may require additional resources for supporting staff effectively and also training for staff to carry out the support function.

Question 4:

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

Quarterly Bi-Annually Annually Other (outline below)

To allow for actions from incidents to be agreed and progressed before publication annual reporting would seem the most appropriate. However, some incidents that are work in progress should not be disclosed until completed.

Question 5:

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

Support staff, administration, communication staff, chaplains, trainers, Occupational Health & Safety Advisory Services (OHSAS) and increased system staff (Datix).

Question 6a:

Do you agree with the disclosable events that are proposed ?

Yes No

Need clearer definitions on how these will be agreed across NHS Scotland.

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

Yes No

As long as they are well described and defined to allow consistency across NHS Scotland.

Question 6c:

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

In the context of children and social care the duty of candour definition of a disclosable event my view is that it is likely to be the same or similar to the criteria for a significant case review (SCR) (see below for extract from the up-dated draft National Guidance for Child Protection Committees for Conducting a SCR out for comment). This is a nationally agreed criteria for child protection committees. In terms of a duty of candour would be an unintended or unexpected death of a child who is in receipt of services from both

health and social work.

For health only a duty of candour, this would still be where a child is seriously harmed or who died and is in receipt of health services.

Criteria for establishing whether a case is significant

A significant case need not comprise just one significant incident. In some cases, for example, neglect cases, concerns may be cumulative.

Criteria

When a child dies and the incident or accumulation of incidents (a case) gives rise to significant/serious concerns about professional and/or service involvement or lack of involvement, and **one or more of the following apply:**

- Abuse or neglect is known or suspected to be a factor in the child's death; and/or
- The child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR. This is regardless of whether or not abuse or neglect is known or suspected to be a factor in the child's death unless it is absolutely clear to the Child Protection Committee that the child having been on the CPR has no bearing on the case; and/or
- The death is by suicide or accidental death; and/or
- The death is by alleged murder, culpable homicide, reckless conduct, or act of violence; and/or
- At the time of their death the child was looked after by, or was receiving aftercare or continuing care from, the local authority,

When a child has not died but has sustained significant harm or risk of significant harm as defined in the National Guidance for Child Protection Scotland, **and**, in addition to this, the incident or accumulation of incidents (a case) gives rise to serious concerns about professional and/or service involvement or lack of involvement and one of the following criteria apply:

- The child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR. and/or
- The significant harm is by attempted suicide; and/or
- The child was or is looked after by the local authority.

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
- List of categories
- List of exclusions

Question 8:

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

Through the Board Clinical Governance Committee.

Question 9:

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

This would be dependent on individual circumstances. A non punitive/supportive approach should be used until all circumstances are clarified.

Perhaps look at the Health and Safety Executive (HSE) Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable incidents and test what happens there.

End of Questionnaire