

**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

Comments NHS Lothian welcomes the focus on transparency and honesty with people who use our services. This reflects one of NHS Lothian's 5 values – "Openness, Honesty and Responsibility"

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

Comments Yes. NHS Lothian has already implemented work of the 'Power of Apology' throughout the organisation – from the Internship / Newly Qualified Registered Nurse Programme through to the Executive Director team.

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

Yes X No

Comments Yes – information is already freely available to the public through inspection reports, Freedom of Information requests and publicly available NHS Board papers which include quarterly reports around complaints and adverse events and an annual report which is widely available to the public

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

Yes X No

Comments Yes. However, the proposal suggests that the amount of information given to the individual should be determined by the wish of the person who has been harmed. This may be difficult when or if a person is cognitively impaired.

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

Yes No

Comments Yes

Question 4:

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

Quarterly Bi-Annually Annually Other (outline below)

Comments Annually to avoid the risk that any incident could potentially identify individuals if the numbers are small

Question 5:

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

Comments NHS Lothian has invested significant resources into supporting staff both in investigating significant adverse events as well as involving both staff, patients and their carers. There are 50 Quality Improvement Teams across Lothian which monitor adverse events and learning from these events. However, it is difficult to see how the notification that is made to the relevant person should be given **personally** by a suitably trained representative of the organisation (6.5) involving a face to face meeting (6.8) – how this might happen in practice.

Question 6a:

Do you agree with the disclosable events that are proposed?

Yes No

Comments These seem to include a very broad range of occurrences (9.12). Events that result in unplanned re-admission to hospital may be a result of considered risk enablement rather than due to avoidable harm. Risk aversion around hospital discharge/admission is an area NHS Lothian is actively seeking to address, and we would not want concerns around re-admissions to result in unnecessarily longer lengths of stay in hospital. Events that attract national media coverage often cannot be predicted and do not necessarily reflect severity of harm – which is acknowledged in the consultation document.

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

Yes No

Comments The Self Directed Support Bill, the shift towards outcomes and personalisation all have as their underpinnings an emphasis on user choice, control, flexibility, participation and innovation – this can easily be inhibited by professional risk aversion which does not promote the cultural shift of risk enablement

Question 6c:

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

Comments

This should reflect adverse events reflecting a similar focus as has been suggested re adults, where unintended harm has been caused. This should also include significant case reviews where things have gone wrong for children

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?

Comments Ensuring that information from DATIX (DATIX is the electronic risk management information system used by NHS Lothian to record information relating to adverse events, complaints, claims and risk registers) supports processes to ensure effective mechanisms to determine if an instance of disclosable harm has occurred.

Question 8:

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

Comments As part of current local arrangements eg through the Quality Improvement Teams and our own professional and patient safety agenda as well as via external scrutiny eg HIS inspection visits. Given the breadth of the suggestions around what would be included and monitoring, it is difficult to see how these would be measured/recorded.

Question 9:

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

Comments As in all investigations the focus should be on the principles of a just culture and take a systems approach – i.e. not focus on individuals to ensure learning from the adverse event with a consideration of contributory factors rather than causes. The aim is to ensure a consistency, systematic and thoughtful approach to disclosable events to promote a greater climate of openness and opportunities to identify system failures and to make service improvements, whilst, at the same time, recognising that there is an

individual and those that care for that individual at the centre of the 'event'.

End of Questionnaire