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 ☐

As per recommendations there should be a statutory duty for organisations that ensures that care organisations proactively take steps to improve their systems and support a culture of learning.

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 risk to service reputation and the ramifications of inappropriate management of cases are so complex that staff must be trained

Responsibility should rest with organisations to ensure that all staff who are asked to be involved with disclosure have access to the relevant training, supervision and support before, during and after their involvement with disclosure communications.

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

Yes x No ☐

There is a need for complete transparency if public trust is to be maintained

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

Yes x No ☐

Organisations should be required to include a summary in their reports of the support that is available to patients, families and staff following a disclosable event.

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

Yes x No ☐

The guidance produced to assist organisations in implementation of the organisational duty of candour should include resources to support the process of notification, staff support and public reporting.

Local procedures for handling complaints or responding to adverse events/significant events are already in situ however these will require review to ensure they are robust to meet the statutory duty of the organisation.

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

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

There should be an annual review process during the ministerial board review with a report including completed reviews in addition to open episodes

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

Training for investigation and communication within the organisation as well as with persons affected by harm. Administrative and reporting mechanisms would have to be developed and training in their use undertaken.

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

Yes x No ☐

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

Yes x No ☐

Yes there is also a need to ensure that there is a method of reporting safety and security risks/ breaches/near misses in non-patient areas which will

have an impact upon patient care e.g. IT failures, procurement systems.

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

Unable to comment

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?

Root cause analysis SEA/ Outcomes evidence of application and involvement of all relevant professional groups and if necessary patient representatives.

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

The proposed organisational duty of candour would be monitored through the existing performance monitoring, regulation and/or scrutiny arrangements that apply to the organisation.

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

Executive teams and Directors should be held accountable for any non-disclosure.

End of Questionnaire