

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

Legislation will provide impetus and detail which is important in order that organisations know what they need to report upon and what they do not. Legislation and guidance must also stress the importance of the cross overs with Adult Support and Protection (ASPA) and Child Protection and to make referrals under this legislation where necessary. Cross referencing here is important so that organisations do not see the issue through one lens or another but understand the different processes that are required and for which they already have duties to report.

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

The support, knowledge and skill set also needs to take account of the fact that it may not be appropriate for the worker involved in an incident to be the point of contact or that they will require support in carrying out these duties.

The skill and knowledge should also incorporate developing staff's understanding around scenarios where the subject of the duty of candour report was or was likely to be an adult or child at risk of harm and the duties of those involved in this regard. This legal duty should perhaps be referenced in any new statute and guidance to emphasise the need to carry out both duties.

It is important that any new statute or guidance cross references itself with existing statute to remind services of their duties.

It will also be worth noting that where there is a duty of candour report there may also be the need for a Significant Case Review, ASPA inquiry or Large Scale ASPA inquiry (where the situation arises in a hospital or care home setting).

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

Yes No

As above there needs to be clear guidance here and consideration of the cross over with other necessary processes such as Significant Case Reviews. Linking the learning from such reviews to the learning from Duty of Candour reports would be a useful local and national resource, perhaps supported by central collation and publication.

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

Yes No

How this is done would need to be proportionate and appropriate. Will all instances require a face to face explanation, will there need to be an assessment of the persons needs in relation to receiving and managing the information. Who else should be advised? How and in what way will family members or significant others be involved?

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

Yes No

As per 3b

Question 4:

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

Quarterly Bi-Annually Annually Other (outline below)

It may be beneficial to consider whether such reporting could be linked to other existing reporting schedules, whatever these may be.

With regard to frequency, an annual return may suffice, perhaps with the caveat that if a certain number of reports are generated within a particular period then an earlier report be required. It may also be worth considering whether the nature of the issue requires more immediate reporting. This would allow policy and inspection teams to consider issues where there appear to be clusters of or very significant reports, in order that advice and support to practitioners can be provided and any underlying issues ascertained as they arise.

Question 5:

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

Depending upon frequency this may require additional specifically trained staff. Perhaps neighbouring agencies could provide a pool of people able to carry out such training and support. The additional resource implication that

would require to be addressed is the need to report certain instances under different processes e.g. Duty of Candour, Adult Protection and perhaps for SCR.

Question 6a:

Do you agree with the disclosable events that are proposed?

Yes No

The disclosable events appear to have largely been derived from a health perspective. In addition to this the terms used may not be accessible/recognisable to the public. It may be more useful to use existing terms categorized into the broader physical or psychological harm arenas. Whether an event is media worthy and has the potential for negative press seems to be more an organizational risk and does not reflect the harm experienced by the individual. Moving in this direction appears to move away from the original intention. The categories chosen would need to consider the intention of the duty of candour e.g. the impact upon service users and patients as opposed to the impact upon organisations.

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

Yes No

As it stands they may not be and hence the need for broader categories as noted above. Maintaining consistency and removing complexity where possible are important especially where trying to communicate such messages to the public. With regard to staff the lessons from Adult Protection implementation would suggest that the messages need to be clear and straightforward removing any ambiguity about when a report is necessary.

Question 6c:

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

The document references the traumatic effect of receiving a child into care (which of course also happens with regard to adults). By making this a 'category' on the basis that it causes further trauma is interesting but is it realistic? What other options are open to health and social care professionals when faced with situations of harm and abuse that cannot be protected against within the community? Being received into care is likely always traumatic on some level and clear guidance would be required to avoid the need to make a report under duty of candour in every such case.

The starting position here appears to have been with health scenarios but careful consideration is required given the differing perspectives and different types of harm that can occur. Broader categories can answer this but will then require much greater definition, perhaps in the form of a decision tree. It may be useful to approach it from both health and social

care perspectives offering definitions with meaning in both fields.

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?

The incorporation of child and adult protection criteria would provide a very useful starting point. Some concern has been expressed at the low rates of referral in terms of adult protection from health agencies and the high rates of referral from Police Scotland. There may be lessons here in terms of designing and introducing the criteria.

Where a report is made under Duty of Candour the report should contain details as to whether an adult or child protection referral has been made and where it has not, provide detail as to why not. In addition the report should contain a statement as to whether any review will be undertaken and if so under what auspices.

There are several mechanisms but in health HIS have recently produced: *Learning from adverse events through reporting and review: A national framework for NHS Scotland* and in terms of Adult and Child Protection Committees, draft guidance is being considered by Scottish Government with regard to Significant Case Reviews.

Question 8:

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

Perhaps it could be monitored via existing mechanisms, extending the role of HIS and the Care Inspectorate in order that it can be incorporated into inspection methodologies.

Question 9:

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

Non-disclosure should reflect other sanctions already in place at an individual professional and organizational level. There certainly needs to be organizational level accountability which should perhaps rest with the CEO and links to professional registration should perhaps be considered.

End of Questionnaire