

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

Comments The Fife Health and Social Care partnership supports the principles underlying the proposed Duty Of Candour legislation. This is consistent with accountable practice and ensures clear joint framework in place for health and social care services as we move forward to integration. However account needs to be taken of existing frameworks in place for reporting ie Adult and Child Protection procedures, HSI, Mental Welfare Commission, Care Inspectorate requirements, reporting of criminal offences, SSSc requirements. Legislation would need to ensure clear co-ordinated approach/framework to reporting within the context of existing requirements and ensure that within the context of current reporting arrangements additional requirement through legislation is necessary.

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

Comments This is consistent with current requirements for staff registration with appropriate professional bodies and Care Inspectorate registration requirements. However would need to cover arrangements for staff/volunteers not subject to these registration requirements and set minimum standards for knowledge/training.

It is fundamentally important that staff have adequate knowledge, skills and support to fully support the organisational duty of candour. Consideration of sustainability also needs to be considered.

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

Yes No

Comments This information could be requested through existing FOI arrangements. Unclear what the benefit would be to an individual, wider

public or organisation of formal publication of disclosure.

The principle of public disclosure is sound; however in practice there would need to be clearly understood definitions. In health for example, if 10-25% of patients suffer harm, given that we admit ~100 patients per day that means we will need to have mechanisms to disclose harm to 10-25 people per day. There is an issue here about the logistics for doing so and a concern that it potentially could undermine public confidence in the service.

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

Yes No

Comments proposed requirements are sound, however there needs to be clear guidance issued as to what level of information is shared, in what format and by whom. Timescales also need to be clear. In NHS Fife, the work relating to Significant Adverse Event Review has provided a good framework to support informing people of harm.

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

Yes No

Comments It is essential to ensure individuals are fully supported in this process.

The principle of support is fundamentally important; however it would be helpful to define what is meant by "reasonable support" in the consultation document.

Question 4:

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

Quarterly Bi-Annually Annually Other (outline below)

Comments Need to ensure that reporting frequency does not place onerous burden on organisations. It may also be useful to link this to reports relating to complaints and feedback. In NHS Fife we have moved towards

composite data; looking at mortality/morbidity, incidents, complaints, claims.

Question 5:

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

Comments This is difficult to quantify at this stage but the proposals do have resource implications in respect of the management, overview and administration of this process, any staff training requirements and provision of suitably trained representatives to deal with these issues.

In NHF Fife we have seen significant resource requirement linked to SAER work. This is essential work which is however resource intensive.

Question 6a:

Do you agree with the disclosable events that are proposed ?

Yes x No

Comments In principle, but guidance needs to be absolutely clear as to what is a disclosable event to avoid interpretation and doubt. Psychological harm within a social care setting may be problematic to determine and quantify particularly within the timescales.

NHS Fife's SAER process lists similar disclosable events; however it is important to recognise that some people suffer prolonged psychological trauma from apparently minor events.

With regards to prolonged physical or psychological harm, the question is by whose definition? By definition any physical injury is likely to cause scarring which will never go away.

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

Yes No

Further clarification required for foster care/ childminder settings

Applicable in Health & Social Care Settings.

Question 6c:

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

Comments The statutory reporting requirements including death of a child in

care or significant incident reported to the Care Inspectorate should be reviewed to ensure fit for purpose.

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 Definition of reportable incident needs to be absolutely clear.

Effective mechanisms can only be employed where staff are knowledgeable and recognise the importance and value of reporting. The culture of the organisation also needs to be such that people will be willing and feel able to report.

Question 8:

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

This could be monitored through existing regulatory frameworks ie Care Inspectorate

Through existing mechanisms, seen as element of composite data and not as stand alone.

Question 9:

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

Comments This could be dealt with in existing arrangements ie, disciplinary process, reporting to appropriate registration body, reporting to police/consideration of listing within PVG scheme

Mechanisms exist locally within the Health & Social Care Partnership to deal with noncompliance with policy/procedure.

End of Questionnaire