

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

Comments Definition and scope requires to be fully understood and applied equitably across Boards.

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

Comments Achieving this may be a challenge

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

Yes

Comments the need to avoid person identifiable information, especially in rural Boards is very important.
There is also the need to collaborate and agree with Family, Next of Kin or significant others.

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

Yes

Comments Consideration required regarding Capacity of the person concerned- The Welfare Power of Attorney who should be informed if person is lacking capacity may not necessarily be next of Kin.
Discussed Poly pharmacy in Older Adults and the understanding required that contra-indications of prescribed drugs may take some time to emerge.
There could be some ambiguity such as when a person decides to disregard advice and an adverse event occurs (e.g. .advised not to walk unaided then falls resulting in a fractured neck of femur).
Requires careful consideration to take every step required to mitigate risk of the adverse event.

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

Yes

Comments Training for staff in disclosing harm to patients/relatives is paramount. Staff need to feel adequately prepared, supported and trusted to communicate to questions from patients & relatives in a Learning Organisation which supports & endorses actions taken.
Requires infrastructure and resources (visibility, funding, commitment and people).
Requires to be signed up to & endorsed by all Professional groups to be effective. Escalation process required such as the existing process for non-compliance with HAI standards.

Question 4:

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

Annually

Comments

Internally- Through existing Governance arrangements –Healthcare Governance Steering Group bi-monthly.

Externally- Summary on annual basis.

Question 5:

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

Comments Best practice thought to be dedicated resource as with job evaluation to reduce risk to organisational if undertaken in an inappropriate manner. Dedicated independent trained individuals with appropriate knowledge, skills & experience of particular Clinical areas. Complete in pairs for concordance.

Question 6a:

Do you agree with the disclosable events that are proposed ?

Yes

Comments

9.12- suggest could be ambiguous, requires to be intensive care as a result of a clinical care error.

Suggest opportunity to amalgamate 9.13 into 9.9

Suggest 9.14 require input from Social Care staff & collaboration from all agencies.

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

Yes

Comments In all appropriate settings

Question 6c:

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

Comments Should be comparable to Child Protection Policy and Scottish harm index.

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 Infrastructure and measures as outlined in response to question 3c.

Question 8:

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

Comments Internally through existing Governance structures.
Sit within Performance Reviews, reported to the Board and as part of Annual review.
Externally as part of HIS reviews and appropriate scrutiny bodies such as the Mental Welfare Commission.

Question 9:

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

Comments Investigate & follow escalation process
As a credible & transparent Learning organisation there is the need to acknowledge that there are instances where things can go wrong and improvements required should be put in place.

End of Questionnaire