

## 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

This should be happening without legislation as it is a professional responsibility.

I agree with the principles laid out in this consultation.

Candour is a good thing and therefore have no issue with the approach suggested with the following caveats:

- Clinicians and managers will have to be very well informed on what harm is: some people churn out meaningless 'I am sorrys' that are neither appropriate nor necessarily sincere.
- Would welcome some detail about some specific instances e.g. what constitutes a 'return to theatre'. Some patients' 'return to theatre' are not due to clinical iatrogenic harm.
- No problem with major sanctions against people who do not do the right thing (suitable defined and fairly assessed): these may be people who are not sympathetic to direct patient contact.
- Have reservations as to how an organisation as vast as GGC could afford all of the clinical and admin time that will be required and the outcome of the 'law of unintended consequences' that may well be known in some of the countries that have adopted this but may not be transferrable to an entirely public funded organisation such as the NHS.
- That stated, these costs might well be offset if there is a true reduction in complaints and legal events.

I have reviewed the consultation on the proposals to introduce a statutory duty of candour. I have no real issues with it and consider it to be ethically and morally appropriate and consistent with a culture where we are actively encouraging transparency.

The Berwick and Francis reports are both explicit about this. NHS GGC has also recently been more explicit about our duties here within the revision of our significant incident policy. Whilst this should now be happening as part of due process, we are probably not routinely reporting on this and I note that the consultation is suggesting that all organisations would be required to report this publically. We probably need to firm up on arrangements of how this would be done within GGC.

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 staff may also require training.  
This may be happening in some areas but may not be consistent across services.  
I don't think that this is new to our organisation, however, accept that there are variances in how this is applied.  
Support for staff in respect of training (particularly communication), professional guidance and on occasion pastoral support, will need to be robust and effective to enable full implementation.

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

Yes X  No

Disclosures should be anonymised and report on any learning or improvement actions that have been put in place.  
Agree with consistency across all organisations.  
No, not routinely.  
Clear guidance will be required to enable the application to be consistent for all disciplines and directorates, and auditable.

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

Yes X  No

Each individual incident should be dealt with based on merit and with a knowledge of the user and the service to ensure sharing of information is dealt with honestly and sensitively.

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

Yes X  No

People should also be supported when disclosing events.  
Agree.

Question 4:

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

Quarterly  Bi-Annually  Annually  Other  (outline below)

Depends on the level of harm and when there are ongoing issues.  
More frequent reporting would be extremely labour intensive.

Question 5:

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

Organisational policy; flowchart of procedures to be followed; support for staff; continuous training and updates for staff; psychological support for staff.

Organisational guidance, appropriately trained staff, use of existing resources e.g. complaints process.

This will differ depending on individual services and how they currently collect, review and report information.

Question 6a:

Do you agree with the disclosable events that are proposed ?

Yes  No

Comments

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

Yes  No

This will be entirely dependent on the systems currently in place.

No – needs national definition. Think more health related causes of events e.g. drug errors, suicide, pressure area damage which is life limiting, fall etc

Question 6c:

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

An agreed definition: more specific examples e.g. child protection, wilful neglect

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 ?

Clinical commitment using standardised reporting systems.  
Admin, clinical and managerial time to pull data, review information and produce reports.  
Confirmation and availability of required support structure for staff, patients and families involved and the wider workforce and population to ensure no further harm as a consequence of the way in which the information is shared and reported.  
National definition/framework required – appropriately trained staff per HSCP, reviewed by clinical governance forums. How will this be shared across HSCPs if an incident occurs which is applicable across the Board?

Question 8:

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

By review of annual reports and periodic review of internal systems including staff and user involvement.  
Staffs trust in the organisation, lack of support for staff and a blame culture.  
Annual reports, existing monitoring or governance structures, patient/family satisfaction with the process. Joint inspections.

Question 9:

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

This would need to be reviewed in the light of the individual circumstances and if there has been an intention to deceive then it should be dealt with as any other professional competency issue and in line with the current HR policies.  
Discussion should take place as to why this has happened. Address any issues raised (lack of training). Ensure that staff are aware of what they should do and monitor.  
Before consequences are discussed, the person involved should have a chance to give their account as to why the disclosable event was not reported in the first instance. It is dependent on the seriousness of the event. If the event is severe the organisation should be penalised. If minor, the organisation should be given a warning and monitored closely.

**End of Questionnaire**