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 ☒

There is general agreement that introducing an organisational duty of candour will enhance and support the current professional duty of candour which exists, to a great or lesser degree, with all professions working in health and social care.

There is less agreement around whether this requires to be within a legislative framework as reporting systems currently exit related to performance.

The proposal as it is currently written does not provide clarity around what would, and what would not be included. Specifically, clarity of understanding around psychological harm is missing.

On balance, the proposal to develop a legislative organisation duty is supported.

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 ☐

Potentially yes, however there is general agreement that only in a few areas there will be a training/skill enhancement requirement. As the duty of candour is embedded in professional regulation there should not be a requirement for wholesale training of all staff i.e. many should already have and be using the skills.

There is a risk that we make ‘disclosure’ as specific and exclusive skill set, rather than an expected skill within existing practice.

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

Yes ☐ No ☒

No, this is just another industry taking resource away from focusing on care delivery.

There is general disagreement with the requirement to publically report on disclosures that have taken place.

The question related to this is: to whose benefit is the publication of all disclosed events? If the aim of the legislation is to ensure we disclose harm to those involved, then there would be little or no benefit to them, of having this further published.

The requirement (NHS) to publish information on Significant (SAER) already exists. When an incident of harm occurs that has not reached the SAER threshold, the 'list' of harm will serve no useful function, indeed it is likely to impact on public confidence at a population level.

Does it matter if one area has more or less disclosures than another? Would the public want to know of every 'error' or instance of harm? What is the advantage of this approach?

As no such requirement to amalgamate and disclose events exist within Local Authorities this would inevitably lead to additional bureaucracy without any additional added value.

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

Yes ☒ No ☐

Absolutely agree with this – it is a professional requirement of every regulatory body, it may be that we need to be more explicit via that route – indeed this may require great clarity of what an disclosable event actually is (at a practical level).

There is universal agreement that the default position is that people who are harmed through the delivery of health or care provision should be informed. In circumstances where it is assessed as causing more harm by disclosing an event, there should be very senior clinical/care leaders involved in making this decision - it should also be formally recorded why this decision was made.

However the thresholds of harm within the consultation document lack clarity within a wider health and social care context using as it does a 'health matrix' of harm.

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

Yes ☒ No ☐

Yes – a range of support options should be offered to individuals/families impact on by harm caused through interactions with health and/or social care services. This may include being able to discuss treatment/care options with an independent professional not involved in the current delivery of care.

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

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

This question lacks clarity around which 'reporting' it is referring to. In answer 3a we did not agree with the requirement to publically report on every disclosure; this question presupposes the answer (in 3a) would have been yes.

However the requirements to confirm 'the organisation' has met its duties round disclosure should be made via the NHS annual review process and through the Local Authority KPI system; noting this is a confirmation of compliance rather than a case by case reporting.

Additionally, consideration needs to be given as to how Integration Joint Boards can play an active role in ensuring and supporting that appropriate and timely disclosure take place within Partnership services. The currently proposal takes no account of future structures (Partnerships) for delivering services.

Lots of reporting will simply make people feel punished, which is surely not the underpinning principle being pursued.

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

Some training may be required for staff in the process of disclosure, as this is within the Code of Conduct of most/all professions this should already be within the skills sets to meet professional codes. However access to advocacy services, patient and staff care resources in addition to current leadership and management structures may be beneficial.

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

Yes ☐ No ☒

They lack clarity and are primarily healthcare related.

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

Yes ☐ No ☒

No, they lack clarity and are not applicable across all care settings, indeed there is a predominant focus within the acute healthcare setting.

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

Harm, just the same as harm to an adult – it is inconceivable that we would have a different standard applied to children's care – health or social care.

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 ?

Training, support, robust and fair processes, clear understanding of what an event is – currently this hasn't been articulated.

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

Appraisals – PDR meetings – Governance structures which would include adverse event reporting via established process (or to be established processes e.g. HSCPs).

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

Corporate accountability at Chief Executive and senior officer level where they have failed to establish a robust system to support disclosure.

End of Questionnaire