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 ☐

The Scottish Ambulance Service supports the requirement for organisational duty of candour for all providers of health and social care. In legislating however there is a need to ensure that arrangements do not become burdensome, are designed to support openness and improvement and unintended consequences learned from other health systems who have legislated are mitigated against. It is also the view of the SAS that an agreed, consistent definition of the term "harm", in the context of duty of candour, is required which would help ensure all health, social care and third sector organisations report against a common understanding of the term.

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 ☐

This requires some additional consideration by care providers as developing appropriate, robust processes, ensuring patients/families/carers are consistently involved at the most meaningful point(s) of the process and undertaking frank, sensitive conversations are skills and knowledge that may not be deliverable across all staff. Additionally there is undoubtedly a resource implication for organisations in terms of ensuring appropriate time and commitment can be afforded to this issue. A resource analysis and programme of development should support this aim with organisations accepting responsibility for disseminating skills and knowledge amongst staff ranging from a "basic" through to "expert" capability.

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

Yes X No ☐

It would appear sensible that the principle of Duty of Candour should extend to the wider public domain to maintain confidence in the integrity and credibility of public services. Any public report however should only be published when it's clear that ALL parties (patients, families, carers & staff) involved in individual cases have had the opportunity to view and consent to information intended for release. Guidance would be required to ensure any public reporting maintains consistency with other legislation & principles relating to the use of patient/ person identifiable information e.g. Data Protection, Caldicott. Finally, any report must also contain the learning from

each incident to avoid the consequence of it avoidably damaging public confidence in a particular care provider.

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

Yes X No ☐

There are some issues regarding organisational responsibility particularly in a system which operates in a much more integrated way. These need to be thought through to ensure all organisations involved are at least appropriately sighted on issues prior to disclosure.

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

Yes X No ☐

The term "appropriately supported" requires some further definition. Is it, for example, a single accessible point of contact within an organisation for the person harmed, relatives and staff or is it access to more complex support e.g. counselling? Additionally the provision of appropriate support again raises the issue of ensuring organisations are adequately resourced to provide this to a meaningful standard.

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

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

While there is an argument for more frequent reporting in terms of maintaining focus etc an annual reporting cycle would reflect the current formal review period for organisations and this report may be suitable to be included in this.

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

This would require to be considered on an organisation by organisation basis. The implications in terms of time and resource during an individual disclosure appear likely to be intense and will require highly skilled staff to lead the organisations response at this point. The review process and analysis of the outcome of this will again require a period of dedicated time and skilled staff. Consideration of the resource requirement (including the need for costs to backfill positions) has been highlighted a number of times throughout this response and there is, in the view of the SAS, a genuine need to ensure this area is addressed as it's essential if duty of candour is to be implemented effectively. Organisations will also need investment in the capability of their leadership to fulfil this type of role meaningfully. Finally, the availability of facilities to allow training, review work and

effectively supporting patients, families, carers and staff would be needed either as shared or dedicated estate.

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

Yes X No ☐

If consistency is to be achieved across health, social and third sector care there needs to be a common understanding of the definition of a disclosable event. Current examples such as "psychological harm" and "unplanned re-admission to hospital" afford the opportunity for individuals and organisations to interpret them differently. This will obviously lead to inconsistent identification and reporting of disclosable events. Further clarity is required here.

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

Yes ☐ No X

The Scottish Ambulance Service has currently occasions where the impact on the patient is unclear at the point where they are passed from the care of ambulance clinicians to partner services e.g. evidence of sensory or motor impairment is not fully clear up to and including the point of handover to ED colleagues. It is therefore difficult for the SAS to determine its part and level of responsibility in any adverse circumstances that emerge. Further consideration and clarity is required on this point.

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

No comment

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?

1. Definitions which are as clear as possible (given the complexity)
2. Embed Duty of Candour within the "Just Culture" ethos
3. Organisational policies & procedures which define responsibility down to individual level
4. Organisations having the capacity through appropriate (in some areas dedicated) staffing & resourcing.
5. Organisational staff who are trained & skilled
6. Outcomes which result in evidence based improvement

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

As part of the normal organisational Executive & Board arrangement and through the scrutiny arm of HIS via adverse events framework.

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

The Scottish Ambulance Service believes that organisations should be held to account through their normal individual and corporate accountability arrangements

End of Questionnaire