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 ☐

We absolutely agree with the principles behind the proposals; that health and social care services should be continuously improving and that transparency is a key element of this; but it is essential that we consider the best way in which to achieve this. We know that legislation can change attitudes and behaviour, and for this reason we would welcome this legislation, although there may be other ways to achieve the same aim.

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 ☐

It is crucial that staff have adequate support, knowledge and skill. Support is key; without it this legislation may well fail to achieve its aims. Organisational culture should truly value transparency, otherwise this legislation could lead to less, rather than more, candour; if staff members are aware the organisation will be judged on a publically available report detailing numbers of disclosed events, but individuals are not encouraged and enabled to see transparency as more important than reputation, people may not disclose when they should. In order for a positive, transparent organisational culture to be created, everybody working there must have the support, training and knowledge to understand why this is important.

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

Yes ☐ No ☐

We agree in principle with this but have some concerns that public reporting of disclosures could lead to a league table culture by which members of the public use the published statistics regarding numbers of disclosed events to decide which services to use. This could have unintended negative consequences if applied to some children's services, for example children's nurseries. We know that in order to grow and develop children need to learn to take age and stage appropriate risks; a younger child may be encouraged to use the toilet alone with an adult waiting outside, in order to encourage independence; an older child may be allowed to climb a tree with a member of staff supporting them. This managed risk is an essential part of good quality care, and care should be taken that this legislation cannot be used in a way which creates fear of appropriate risk-taking. We

understand that the costs and benefits of risk are very difficult to legislate for but nonetheless this should be taken into account.

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

Yes ☒ No ☐

We agree that people harmed should be informed. It is essential that this initial communication takes place in an accessible way; long letters containing jargon are not easy for those with low levels of literacy skills to understand. If a child has been harmed this communication should take place in an age appropriate way, using language and formats they can understand.

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

Yes ☒ No ☐

This is crucial. The process of learning a disclosable event has occurred will be very difficult for many people, and re-traumatising for some if not handled appropriately. It is key that if support is to be offered, resources are in place to provide this; if staff are already working at capacity and this is in addition to their core workload, people may not receive the level of support they should be able to expect. We would hope that this support would include the person being disclosed to being able to choose the type of support to be provided. Relationships are key; when a family or individual has a relationship with one particular member of staff, it should where possible and appropriate be that member of staff who informs them that a disclosable event has taken place, and who seeks, co-ordinates or provides the ongoing support.

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

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

Comments

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

See question 3c

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

Yes ☒ No ☐

We do not disagree with any of the disclosable events listed but do note that as the list stands it is too health focussed. It is arguably harder to define a disclosable event in relation to social care services than it is for health, but examples will need to be made available for social care services to use when training and supporting staff to recognise disclosable events.
In addition, the definition at 9.9 includes 'any unintended or unexpected event that …resulted in …injury'; as it stands this could include a bump on the head or a child being bitten by another child, two very common occurrences in children's early years and part of normal development. We would question whether events like these should be included in the definition of disclosable event, or at least whether they should be reported on.

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

Yes ☐ No ☒

Social care settings are necessarily complex and it will not in our opinion be appropriate or effective to create an exhaustive list of disclosable events, although there will of course be some events that will always be disclosable. A better approach would be to create user-friendly guidance that encourages staff to learn about risk and harm, to build positive relationships with those they are caring for, and to engage in organisational debate about what should be disclosed.

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

See question 6b

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 ?

See questions 2, 3a, 3c, 6a

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

The Care Inspectorate could monitor this duty as part of its ongoing inspection routine. This would have the added benefit of encouraging an improvement-focussed ethos.

Question 9:

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

In this situation the relevant person should be notified and be made aware that a mistake has been made. The reasons for the event not being disclosed should also be considered within the organisation, and it should be ensured that if this situation arose due to organisational problems such as high caseloads, administrative error, or lack of training and support, these issues are rectified. The error should be reported to the Care Inspectorate so it can support the organisation to improve.

End of Questionnaire