



Scottish
Infected
Blood
Forum

**RESPONSE TO THE SCOTTISH GOVERNMENT
CONSULTATION ON PROPOSALS TO
INTRODUCE A STATUTORY DUTY OF CANDOUR**

January 2015

**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

Comments

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

Comments

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

Yes No

Comments

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

Yes No

Comments

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

Yes No

Comments

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 ?

Comments *SEE ATTACHED STATEMENT*

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

Comments

Question 6c:

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

Comments

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 *TRAINED STAFF INDEPENDANT FOR THE ORGANISATION*

Question 8:

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

Comments *YES*

Question 9:

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

Comments REFER TO FITNESS OF PROFESSIONAL BODY - ON JUSTICE DEPT

End of Questionnaire

Chapter 2;

Raises questions regards how terms are defined, e.g.

5.2 What is the definition of Minimum requirement? If the organisation really believes in transparency its aim should not be the minimum.

6.1 How define relevant person

6.3 What would be classified as reasonable support?

Sections 7....

Reporting adverse incidents little is included in this section about patients and families section 7 refers to existing manner for handling complaints or significant event there are many example where individuals feel that it is like the police investigating themselves thus there is a lack of confidence.

Chapter 3;

Section 9.1 we would agree that there is an urgency to provide a definition that is transparent regards the meaning of 'Harm' or Adverse Event. This definition should take account of the patient and their families and public understanding rather than that supported by the organisation.

Section 9.7; organisations have arrangements in place such as psychological harm. Such recommendations have been made by in other consultation reports, but the lack of these professional personnel means such recommendation appears to be lip service!!

Chapter 4

Section 10 Monitoring via existing performance monitoring leave could result in nothing happening. There requires being an arm's length body to monitor Duty of Candour if the public are to believe in openness.

Annex A

We would agree that "denial and dismissal of mistakes often result in distress and people spending several years seeking the truth, accountability and apology". During the past fifteen years there have been several Reports, Parliamentary and Privately funded Inquiries and Judicial Inquiry which commenced in 2009 into infected blood and its report is yet to be published. The cost to date could be at least twenty million pounds. The result is that many infected/affected have died or are seriously ill.

SIBF believe that the Duty of Candour should provide easy access, particularly for those who are not competent or confident self-advocates .There needs to be a "level playing field so that the "small person" (patient who has been harmed) does not feel intimidated or overwhelmed by the might medical establishment.

Ignorance of best professional treatment should not be a viable defence.

There needs to be more work around incidents when a patient or group of patients are harmed not by the error of a medical practitioner, but because of a policy or systemic failure.

As previously stated deadlines should not be imposed in cases where the effects of a detriment are not immediately obvious, such as a viral infection that is undetected and lies dormant for many years before affecting the patient.

There should be more work to consider situations of neglect to disclose a detriment, being a form of "commission vs. Omission", or doing harm by doing nothing or not fully informing.

Some people will require advocacy or advisory support and this should be made available through a separate body such as Action against Medical Accidents.

We believe that if a meaningful "Duty of Candour "is introduced then the general public will have greater confidence and would do away with the public perception of the medical finding themselves "closing ranks".

Where an adverse incident arises against an individual medical professional, there should be a system of maintaining a record which would highlight a recurring problem.

Additional Comments

Adequate provision must be made to ensure that the members of staff who make the disclosure to patients/relatives are highly trained in communication skills and also have appropriate and specific knowledge of where supports can be found and where information on related service can be accessed.

This requires a co-ordinated approach to training across NHS Scotland so that consistency and accuracy in disclosure will result in patient confidence in the system.

Philip Dolan MBE KHS



Convener – Scottish Infected Blood Forum

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