

## 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

This will be in line with England and will ensure that patient have the same right wherever they are treated

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

This is a vital part of overcoming barriers to disclosure. Staff must be confident in communicating appropriately and be given support. Staff able to communicate this without causing undue anxiety must inform patients of events.

SIHA thinks that there is a need for clear definition of reportable events. We note in the list of possible reportable events (9.12). However, the headings are not in themselves helpful e.g. return to theatre, re-admission etc. taking these as examples they can be a straightforward common adverse outcome that should already have been fully discussed with the patient or indicative of something more serious . An example is return to theatre – this could be haematoma or retained instrument swab. One not reportable the other would immediately invoke the candour process.

Considerations would also be required with a view to the training and development needs of staff.

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

Yes  No

This is needed for transparency. However, how, where and when the publication should happen will need a great deal of thought and consultation. The Independent Sector would welcome inclusion in this discussion.

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

Yes  No

The responsibility of the organisations to identify the most appropriate and skilled person to carry out this duty is welcomed.

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

Yes  No

It is very traumatic for all the people involved in an event and it is important that everybody involved are supported appropriately.

Question 4:

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

Quarterly  Bi-Annually  Annually  Other  (outline below)

This could be aligned/ cross referenced to what is already submitted as notifiable incidents to HIS but could form part of an annual or biannual report.

Question 5:

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

It is important to acknowledge the hugely diverse service range this is covering and in some instances single handed care services may need external support to comply with legislation.

Again consideration to the training and development needs of the staff within variable care settings need to be considered as well as the support required. Consideration to the individual's ability to deliver and communicate appropriate messaging within the relevant care setting and the assurances required that this is aligned to legislative requirements.

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

The overall definition of an unintended and unexpected event will be clear in all settings. The outline of definitions for health is clear but need to be drilled down in certain categories, e.g. 9.12. However, the guidance document proposed needs to be detailed in order to be a decision tool. Again SIHA would welcome an opportunity to comment on any proposed guidance document.

A standardised proforma /Process Map would possibly assist staff in managing incidences appropriately and which also highlighted a standardised escalation/management process

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?

As discussed above a good guidance document with a decision tool. In the document examples/case studies would be very useful.

Question 8:

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

The Duty of Candour should be monitored by the regulation and it should be part of the duties of Healthcare Improvement Scotland

Question 9:

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

This should be in line with any other breach of statutory duties.

**End of Questionnaire**