

## 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 were concerned that the question above does not match the question 1 in a consultation document itself which is "**Do you agree that the arrangements that should be in place to support an organisational duty of candour should be specified in detail ?**". Having said that, however, we agree with both statements. We consider that outlining the arrangements in legislation and specifying them in sufficient detail would ensure that there would be standardisation across all the organisations involved.

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 important that all staff who may be required to speak to patients or carers under this duty should be properly trained and supported to ensure that the additional distress of the disclosure is minimised.

**One potential issue is the effect this would have with Professional Indemnity Insurance? There is an admission of blame which other insurers (e.g. car) tell the insured to avoid.**

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

Yes  No

Such transparency is probably to ensure that a learning culture exists within the organisation and should also reduce the amount of time responding to freedom of information requests.

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

In discussing this question, we considered that the word "people" was inadequate and should be expanded to ensure it covers patients, relatives, carers and staff.

Question 4:

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

Quarterly  Bi-Annually  Annually  Other  (outline below)

It was felt that the limited resources of the NHS would be better spent on patient care than on producing excessive reports. This could also form part of the annual Health Board / Organisation review.

Question 5:

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

We consider that each site should have a person responsible for this and this could mirror or use the governance structures already in place.

Question 6a:

Do you agree with the disclosable events that are proposed ?

Yes  No

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

Yes  No

As a healthcare organisation, we do not have enough information on the social care aspects to be able to comment fully. We would, however, consider that disclosable events should be the same for both health and social care.

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 ?

Communication and reporting need to be addressed. This could be through the HIS/governance structures. An organisation's HIS/Governance structure should incorporate a framework that outlines who is responsible for speaking to the patient i.e. the organisation's Incident and Duty of Candour policies should determine which Team/ Business Unit/ individual has responsibility to contact the patient. Careful consideration should be given to ensure the healthcare professional who informs the patient has both the seniority in terms of experience and expertise; possesses excellent communication and interpersonal skills and has a good grasp of the facts relevant to the incident. Further, all staff should be made aware to report errors and also made aware that when they report an incident they will be required to grade the severity of the incident based on the actual harm caused. The person who finds the error should know exactly how and who to report it to. There should also be an agreement who will take responsibility for scrutinising all incidents graded moderate and above to identify those that meet the requirements of Duty of Candour.

Section 7.2 states that "Organisations would also be required to report on the ways in which they have supported staff in the development and maintenance of the skills required to ensure respectful disclosure by staff who are required to be involved with this." Appropriate training will be needed for pharmacists and this needs to be in the job description and rewarded in Agenda for Change.

There is a risk of an adverse effect on relationships with other professionals e.g. if it is a drug administration error picked up by a pharmacist. There need to be mechanisms in place which should include prior communication with other professionals (e.g. pharmacy, when there is a medication error) prior to disclosure of the event and this would therefore help to negate the possibility of any adverse effect on relationships.

Section 7.5 states: "Organisations would also be required to include a summary in their reports of the support that is available to patients, families and staff following an disclosable event. They would also need to describe the provision to ensure that training and development support has been implemented to ensure best practice in disclosure." *Whilst other NHS staff would have a level of understanding of working conditions and stresses etc. there is a risk that if the patient is not aware of this we are back into a blame culture. Information to patients needs to be balanced and done carefully.*

Question 8:

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

HIS reporting to ministers; annual Health Board report and possibly an external and independent dashboard.

Question 9:

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

The appropriate local procedure should be followed and these should include an investigation as to why it has not been disclosed. Possible reasons could include individual or computer error or it may be a training or support issue.

**End of Questionnaire**