

## 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

Organisations should always be mindful of their responsibilities in this regard in any case, however legislative backing to ensure national consistency of approach would be useful.

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

Existing legislation relating to qualification requirements, registration and supervision of health and social care professionals is sufficient.

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

Yes  No

Yes in the form of high-level statistical information only. More detailed reporting on the nature of disclosures for example may be misleading if read out of context - context which could likely not be provided without breaching patient / service user confidentiality.

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

Yes  No

Yes, however the process as outlined in the legislation where an apology is given early in process creates a risk of the organisation being seen to have accepted liability before a proper review of events has taken place.

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

Yes  No

Yes, however it may be advisable to legislate that this support cannot be provided by the organisation in question, as this may lead to a perceived conflict of interest were there to be a future legal claim pursued by the individual with regards to the incident in question.

Question 4:

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

Quarterly  Bi-Annually  Annually  Other  (outline below)

Question 5:

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

We would not anticipate recruitment of additional staff or redeployment of additional / existing resources to support these arrangements. There will be some degree of staff and resource cost in developing, disseminating and implementing policies but there is no realistic way in which this can be quantified at this stage.

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

Given the nature of health and social care services, individuals will potentially understand events, their effects, and therefore the need for disclosure, differently. Additional guidance from government with regard to definitions would therefore be welcomed.

Question 6c:

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

To ensure consistency of practice across all care services, the same

definitions should apply to all services.

#### 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?

- Review of current policies to ensure that processes meet requirements to disclose adverse events as they apply to integrated services. Issues re at what level or by which organisation responsibility is held
- Resource implications in developing and disseminating policies
- Organisational support for staff/service users/patients including potential training needs for staff
- Clarity as to whether organisations are responsible for the compliance of purchased service providers with this duty
- Expected increase in numbers of disclosures with a risk of an increase in complaints and litigation
- Monitoring and enforcement arrangements and development of a process through which learning and improvement actions are progressed, including professional governance groups.

Noted that there is little specified in proposals in relation to harm caused by lack of professional information sharing – which is a relatively common event

#### Question 8:

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

Through organisations' existing professional governance structures.

#### Question 9:

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

Any 'punishment' should be relative to the nature of the incident and the circumstances which led to non-disclosure, for example a very serious incident which is deliberately not disclosed should incur a significant punishment, whereas this would be a disproportionate response where a relatively minor incident is not disclosed for understandable or justifiable reasons.

We would propose that consequences range from a reprimand or warning for lesser offences, to fines etc for more serious incidents.

In addition, we would note that in section 2.2 care must be taken not to conflate "non-disclosure" with "denial and dismissal of mistakes". These are quite separate things.