

## 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 are fully supportive of continuous improvement in relation to quality and safety across health and social care services, and recognise the need for more consistent standards in relation to the disclosure and remedy of harm. However, we do not feel that the case for legislation has fully been made, particularly in relation to social care services. Systems are already in place across social care provision requiring statutory reporting of instances of harm and longer term relationships in social care (compared with healthcare) tends to promote candour in practice. We are also concerned that the evidence base in the consultation is focused on health services with little statistical analysis of social care provision.

We also have reservations about the administrative burden that would result from a statutory duty and do not agree that this would be minimal since some procedures are already in place. The problem with a legislative duty is the lack of flexibility, for example requiring us to 'offer the opportunity to be involved in review of the events' or 'identify and inform relevant person of the learning that was identified' in all instances whether proportional or not. The organisational and reporting requirements are likely to mean that our systems and training arrangements would need to be reviewed and may result in a significant bureaucratic and financial burden. This will depend on the final definition of 'disclosable events'.

It is not clear that legislation is the best or only way to achieve the key policy objectives of a more consistent approach and a culture change towards greater transparency. Consistent guidance and training across Health and Social Care Partnerships may be adequate and the reduced flexibility of a statutory duty may bring additional administrative pressures.

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

If a statutory duty were to be in place it can only be delivered if staff have the appropriate knowledge, skills and support. Establishing this coordinated, consistent approach will require review of existing systems and staff training both of which will have resource implications.

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

Yes  No

This would be a key driver for greater transparency and learning within organisations.

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

Yes  No

Yes, however the proposals are not specific on the issue of an individual's capacity, i.e. where they lack capacity to understand the implication of the disclosure or to exercise their rights. Any statutory duty (or alternative) needs to be clear about disclosure where the relevant individual lacks capacity.

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

Yes  No

Yes, but it is important to recognise that the required support to individuals is likely to have resource implications.

Question 4:

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

Quarterly  Bi-Annually  Annually  Other  (outline below)

Annually seems sufficient for social care settings. Acute and high-volume health services may require more frequent monitoring.

Question 5:

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

This is difficult to answer and would require a substantive review of existing systems in relation to introducing a duty of candour. The key variable is the definition of 'disclosable events'. Issues around the volume of demand (and therefore capacity) will be driven by how 'disclosable events' are defined in the final legislation. With a broad definition of 'disclosable events' and with the proposed support requirements we feel that volume would rise significantly compared with our existing system for handling complaints.

Our view is that a statutory duty would require new local procedures to be developed across social care settings, existing service policies and guidance would need to be reviewed, and a programme of training and

support would need to be delivered.

Question 6a:

Do you agree with the disclosable events that are proposed ?

Yes  No

Agree with the range of events proposed where these are relevant to the harm that has been experienced.

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

Yes  No

It is unlikely that the events will be clearly applicable / identifiable in all situations. It may be difficult for staff to make decisions on whether an event can be attributed as the main cause of the incidence of harm. E.g. it would be very difficult to identify whether a prolonged period in a hospital or a care setting (which may be for a valid reason) has resulted in (or contributed to) psychological harm. It is also important to recognise that events such as unplanned hospital readmissions or delayed discharges can result from a number of inter-connected issues involving different support agencies, environmental factors and issues around informal (e.g. family) support structures.

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 ?

There will need to be effective mechanisms in place to deal with cases that are in dispute. Assuming that the legislation provides a clear definition of harm, there will need to be sufficient expert support and oversight to determine that harm has taken place where this is unclear. In more complex cases there will also need to be oversight to identify the nature of disclosable harm – i.e. which event(s) caused harm and which organisation was responsible for this.

Question 8:

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

The organisational duty of candour should be monitored in line with the

existing regulatory arrangements social care providers.

Question 9:

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

On discovery, immediate disclosure should be made to the relevant person with an apology and support as set out in the requirements for the duty of candour.

The relevant regulatory body (e.g. the Care Inspectorate) should inspect the organisation to ensure that staff have the required skills and knowledge to fulfil the duty. Consequences should be in line with existing practice, e.g. improvement actions set out for the organisation with further consequences if standards do not improve.

**End of Questionnaire**