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 X No ☐

Comments
There is general agreement in principle that introducing an organisational duty of candour will enhance and support current arrangements. There is scope for compulsory disclosure within current professional codes of conduct, professional guidance and health and safety legislation. The framing of the legislation must take cognisance of the forthcoming guidance from the NMC/GMC/HPC.

Several levers exist to deliver a duty of candour, which have clearly not delivered consistency. On balance, legislation will support consistency and promote public confidence across health and social care. The framing of the legislation is crucial. While the principles of openness and honesty are crucial, there are certain circumstances where disclosure could cause harm. The legislation would benefit from scope for discretion. The application of discretion must involve a robust ethical process and recorded rationale for decisions made.

The proposal as it is currently written does not provide clarity around what would, and what would not be included. Specifically, clarity of understanding around psychological harm is missing.

The proposal to develop a legislative organisation duty is supported.

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 X No ☐

Comments

There has been a lack of recognition of the skill set needed to deliver disclosure sensitively and consistently. This should be a core skill set of every health and social care professional, which will require significant investment at a time of a shrinking resource envelope. It should not be a corporate role, given the routine requirement that will be involved. For many it will be building on an existing skill set. There is a strong link to team culture development and reflective practice, where disclosure is delivered in

the spirit of partnership, honesty and improvement (there is no place for paternalism)

There is a risk that we make ‘disclosure’ as specific and exclusive skill set, rather than an expected skill within existing practice.

Consideration must be given to inclusion of such training in undergraduate programmes and vocational training.

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

Yes X No ☐

Comments
In principle, yes. Many professional are cautious about the value of this type of public reporting for two reasons. Firstly, the potential for loss of public confidence in particular services due to assumptions being made about the data. The format of these reports would have to be carefully considered. The question related to this is: to whose benefit is the publication of all disclosed events? If the aim of the legislation is to ensure we disclose harm to those involved, then there would be little or no benefit to them, of having this further published.

Secondly, there is a significant risk that the bureaucracy involved will add a considerable burden to already stretched resources. Detailed scoping work is required to build on existing processes to avoid unnecessary bureaucracy in the spirit of openness.

There is scope to integrate public assurance into existing governance arrangements within Health Boards. This would include planned reports on compliance being considered by the most appropriate governance committee and an annual report to the NHS Board.

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

Yes X No ☐

Comments
Yes – it is a professional requirement of every regulatory body, it may be that we need to be more explicit via that route – indeed this may require great clarity of what an disclosable event actually is (at a practical level).

There is universal agreement that the default position is that people who are harmed through the delivery of health or care provision should be informed. In circumstances where it is assessed as causing more harm by disclosing

an event, there should be senior clinical/care leaders involved in making this decision - it should also be formally recorded why this decision was made.

The thresholds of harm within the consultation document require more clarity and definition within a wider health and social care context.

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

Yes ☐ No ☐

Comments
Yes – a range of support options should be offered to individuals/families impact on by harm caused through interactions with health and/or social care services. This may include being able to discuss treatment/care options with an independent professional not involved in the current delivery of care and access to psychological support tailored to individual need. There is also potential to work in partnership with other agencies including the third sector and public partnership groups.

Staff support is also crucial. Public bodies must have processes in place to support staff with the emotional impact of caring. This would include the process of disclosure. Practical support would include peer support, psychological first aid and clinical supervision.

Question 4:
What do you think is an appropriate frequency for such reporting ?

Quarterly ☐ Bi-Annually ☐ Annually X Other ☐ (outline below)

Comments
This question lacks clarity around which ‘reporting’ it is referring to. In answer 3a we were cautious about the requirement to publically report on every disclosure. The requirements to confirm ‘the organisation’ has met its duties round disclosure should be made via existing mechanisms e.g. NHS annual review process and through the Local Authority KPI system; noting this is a confirmation of compliance rather than a case by case reporting.

Existing governance arrangements should be used. This would include an annual report to the NHS Board and Integrated Joint Boards providing assurance of compliance with the spirit and letter of the legislation.

Question 5:
What staffing and resources that would be required to support effective arrangements for the disclose of instances of harm?

Comments
Training will be required for professional staff in the process of disclosure. Additional resource will be required for clinical leadership, corporate oversight/administration, data analysis, training and support services for patients and their families. Access to independent support will also be required for patients and their families. While this can be absorbed into the existing resource envelope, additional resource would support effective implementation.

Question 6a:
Do you agree with the disclosable events that are proposed ?

Yes X No ☐

Comments
In principle the outlined approach makes sense. More detail is required around definitions and the decision making process associate with disclosure. The current format is health focused and requires to be expanded to reflect adverse events in social care. More guidance and definition around psychological harm is required (e.g. is it limited to a psychiatric diagnosis). In addition healthcare organisations will need to review consent policies and patient information.

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

Yes ☐ No X

Comments
Current format is very much healthcare focused. Please refer to comments in 6a

Question 6c:
What definition should be used for 'disclosable events' in the context of children's social care?

Comments
The same test should apply to both children and adults (harm – physical, emotional, psychological and neglect). Social care element needs further definition.

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
Training for all staff in understanding the importance compliance with the legislation (individual responsibility) and the value of a culture of openness, partnership and learning. Robust systems and processes are required (building on existing adverse events/risk management policies), which include KPI's and an assurance mechanism.

Question 8:
How do you think the organisational duty of candour should be monitored ?

Comments
Via existing governance/ performance structures (at an individual level via PDR/appraisal processes). Consideration needs to be given to governance structures within health and social care partnerships and the relationship with healthcare/social care governance structures in Boards/Councils. External validation could be via HIS.

Question 9:
What should the consequences be if it is discovered that a disclosable event has not been disclosed to the relevant person ?

Comments
Success is linked to individual 'buy-in' and progress towards psychological safety within each team/functional unit. Initially there should be a period of reflection and learning. However, repeated non-disclosure should be dealt with using organisational processes – conduct/capability.

End of Questionnaire