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

Comments

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 ☐

Comments

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

Yes ☐

Comments

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

Yes ☐

We believe that this should also be extended to family members who have a caring role. Carers should always be involved, unless the patient does not want them to be. This is because they are often delivering care on a regular basis and generally have a greater knowledge of the patients needs than the professionals providing them with care. In addition, any physical or psychological effects of errors in their care may also impact on the care that they provide and they must be made aware of these. Particularly, where the patient does not have full capacity and relies on their unpaid carer to articulate their needs. In all cases the patient should be asked if they would like their carer or family members to be involved at all stages - the apology, explanation and the learning process afterwards. Only when the patient says they do not want their

involvement should the carer be left out of the process. Where the patient lacks capacity the carers and family should always be involved

Carers should be treated as equal partners in care. Their role has been defined in legislation (Community Care and Health Act 2002) as 'partners in care' and this has been further strengthened in subsequent government policy through their recognition as 'Equal Partners in Care' meaning they should be regarded as having equal status as members of the paid care workforce.

Carers are not always provided with adequate information and are routinely left out of decision making when it comes to the care of their relatives. The report states that "Of the four cases we reviewed, only two documented some level of engagement with the family or relatives" yet the proposals outlined do not include the systematic involvement of carers in the reporting arrangements or in contributing to service development after an incident. The reasons for involving carers are many, including:

- The importance of treating carers as equal partners in care
- Their knowledge and experience in relation to the needs of the cared for person and the likely impact the incident may have on them. Particularly where that person lacks full capacity and where the carer has guardianship or power of attorney
- The incident may affect the persons care needs and as a primary care giver the carer will need to be aware of this
- The carer may have much to contribute in relation to service development and ensuring future incidents are avoided.
- The carer may require support following an incident and reassurance that this won't happen again. Systems need to be in place to ensure this is not overlooked
- If services to the patient are affected following an incident this may impact on the carers role and on their own health and wellbeing

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

Yes ☐

Yes. Provision should also be in place to support the carer

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

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

No Comment

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

No Comment

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

Yes ☐ No ☐

The focus should not be entirely on physical harm, but also emotional and psychological harm –the carer may also play an invaluable role in identifying the emotional and psychological impact of incidents

The examples given are of very serious incidents which would be likely to come to light anyway – this should be extended to include instances of systematic abuse within institutions, in order to give people the power to expose this and organisations responsibility to address it

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

Yes ☐ No ☐

No Comment

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 ?

One of the mechanisms must be the involvement of carers and family members, particularly where the patient lacks capacity.

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

We agree that Healthcare Improvement Scotland and the Care Inspectorate should be involved in monitoring

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

Each incident should be looked at on an individual basis and responded to as appropriate. This may involve sanctions for the organisation as well as individual workers. Statutory guidance should outline how a failure to implement the duty will be addressed

End of Questionnaire