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 ☐

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 ☒ No ☐

Speech and language therapists (SLTs) need to have equal access to training and support according to need (see answer to question 5 below). There may be learning available from SLT Professional Bodies on America and Australia. RCSLT would be happy to contact colleagues there to explore this.

RCSLT query whether SLTs (or any AHPs) have been involved in *'Learning from adverse events through reporting and review: A national framework for NHSScotland'* or the testing that is currently ongoing within NHSScotland on *'Being Open' guidance* or Significant case reviews? If not, RCSLT would request that these are reviewed for their relevance to SLT (and AHP) services.

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

Yes ☒ No ☐

Yes – but reports must be anonymised so to protect identity and confidentiality of service user/s and individual staff.

This may present challenges where practitioners are working in small services within one of the smaller health boards.

Public reporting may however discourage boards from disclosing harm particularly if boards or social care agencies are likely to be compared for

numbers of disclosure over a given period. Different agencies providing different kinds of care (from low to high risk of disclosable events as listed in the consultation document) may not compare well on “face value” reading.

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

Yes ☒ No ☐

Yes. See “Note on Communication Skills” below (Question 5).

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

Yes ☒ No ☐

Comments

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

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

Annually for all organisations or more frequently by specific organisations if requested by regulators.

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

Skills, knowledge development

Level 1: Training for all staff who in their day to day practice can potentially do or omit to do something which could cause physical or psychological harm.
This “basic” training should include;

- Understanding of statutory obligations and relationship of these to uni-professional standards, codes of practice and ethics.
- Definition of disclosable incident and identification of what sorts of

actions (in their clinical practice) could lead to a disclosable incident. It will be important to make clear to staff the relationship between disclosure and potential litigation.

- It will also be important to distinguish between the act of doing harm through negligence and people being an unfortunate victim of a procedure – with inherent and acknowledged risks - going wrong.
- Direction on how, when, within what time limits and to whom specifically they should report any potential or actual disclosable incidents to.
- Information on the process that would follow particularly in respect of support for them and their service users.
- Practice exercise using range of actual or potentially disclosable incidents.

Level 2: Training for all staff who in their day to day practice are likely to receive reports of disclosable incidents, have to make decisions if disclosable or not and then manage disclosure. This “Disclosers” training should cover;

- All of basic level training plus;
- Development of Competences in communicating effectively with people (service users) with communication support needs (See note on Communication Skills below).
- Development of competences in communicating sensitive or distressing information to people and counselling skills.
- Detailed procedures for each part of process of disclosure management, review of actions etc.
- Practice of managing disclosure process from start to finish.

RCSLT suggest level 2 training should be accessible to all senior clinical staff across professions including each individual AHP profession. Where requested by clinicians support should be made available to access this level of training.

Note on Communication Skills:
RCSLT welcome mention of communication skills (e.g. 6.4, 7.3) however there are an estimated 250,000 people in Scotland with communication support needs (CSN), many living with conditions which require regular medical treatment and / or social care support. E.g. people with dementia, who have had a stroke, frail elderly

- Disclosure arrangements need to be sensitive to the CSN of people involved i.e. SLT service users
- Disclosure training (para 6.5) must include how to disclose to people with CSN.
- Process of review must be sensitive and responsive to CSN of people involved (para 6.6. 6.7, 6.8).

Equality Impact Assessment
Given that clear communication between service user and provider underpins effective implementation of this legislation effective provision for

people with communication support needs is crucial if they are to enjoy equal benefit from it.

RCSLT welcome guidance for organisations. It would be helpful in the guidance on setting up arrangements to alert organisations to communication access / support needs considerations (para 7.6).

Staff time (with costs of necessary cover):
Duty of Candour training should become a key element of mandatory training on induction and annually for staff in post.

Staff will need to be released from normal duties to do the training. Release time should be equitable across professions depending on level of training deemed necessary. So for example AHPs should enjoy the same CPD release time for this training as their medical and nursing colleagues. Appropriate cover for AHP duties must be equally “covered”.

Initial costs to organisations (for training time, cover etc.) are likely to depend on numbers of staff requiring training and efficiency of organisation of this CPD.

RCSLT would be willing to support development and dissemination of information on Duty of Candour and access training to its members and to AHP colleagues via the AHP Federation Scotland.

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

Yes ☐ No ☒

RCSLT welcome the fact that definition of the types of harm that would trigger the organisational duty of candour *“are to be developed and informed through dialogue with health and social care professions, taking due recognition of the different context, nature and requirements in health and social care settings.” (9.1).*

The consultation document appears primarily focused on medical model / acute care services. E.g. Note 4.8: Mistakes in GP practice, Note 4.11 not listing HCPC.

RCSLT believe SLTs could potentially unexpectedly or unintentionally cause physical or psychological harm, for example;

- Wrong diagnosis and therefore management of eating, drinking and swallowing difficulties leading to shortening of life expectancy (if properly treated)
- During procedures such as valve replacement for laryngectomee patients

- Erroneous diagnosis and management of speech, language and communication needs leading to prolonged psychological harm

If this is the consensus interpretation of legislation among SLTs and health and social care colleagues – it would be helpful to provide examples in guidance which were immediately meaningful to SLTs.

More generally there is a need for much more clarity and extended examples – possibly collated centrally and shared over time to ensure consistent interpretation of definitions across Scotland. This might take the form of a "*Has anyone else reported or disclosed this sort of event before?"* online list of examples.

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

Yes ☐ No ☒

No – not as they are now. See comment above re: 6a.

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

Children and young people's services include health, education and social care services (see "Getting it Right for Every Child" and CYP Act 2014).

Disclosable events therefore should be defined for all these context.

RCSLT would suggest disclosable events in the context of CYP services should include;

All listed above for adult services plus

- Events / incidents that lead to immediate or prolonged risk of safety of child's physical or psychological health;
- Events / incidents that lead to prolonged impairment of physical, emotional, intellectual, communication and social capacity or development.

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 ?

- Does the law intend to address more than acute medical care (in primary or tertiary care) – Yes or No?

- If yes – what other “treatments”, therapies or service provisions is it intended to cover and which professional groups are therefore implicated?

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

Within current safety monitoring mechanism as set out in consultation document.

Monitoring should take perspective across health care and not solely focus on medical / acute care and treatment – depending on the definition of disclosable events (see answer to question 6a, b, and c).

See comments under question 3 regarding appropriateness of comparing organisations.

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

- Investigation and assessment on a case by case basis.
- RCSLT recommend the usual disciplinary and / or regulatory council procedures should be followed in relation to responsible individuals.
- Corporate responsibility for organisational compliance should be carried by responsible executive officers.
- Sanctions used elsewhere in the world should be considered.

<u>Other comments:</u>

1. RCSLT members have asked for clarity on how “Duty of Candour” legislation will relate to a currently used electronic incident reporting system “Datix”.

2. Will there be a duty on health and social care professionals to report disclosable events involving colleagues? This will need to be clarified in guidance issued to and by organisations.

3. When does duty start? If an organisation for example doesn’t provide information on services in an accessible format – would this barrier to necessary care constitute an act causing harm to people with communication support needs? This will need to be clarified in guidance issued to and by organisations.

4. Ensuring guidance on “Duty of Candour” is implemented may be a particular challenge where services are provided outside of a multi-clinician setting. Lone practitioners (or those working broadly in isolation within community services e.g. a sole SLT working across community and social care settings) may rarely or never re-examine their own clinical decision making and there will be no colleagues to reassess decisions or actions taken. Legislation and guidance will need to ensure these clinicians are encouraged and supported to apply guidance.

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End of Questionnaire