

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

Yes though detail and examples if possible for different staff, recognition of potential of risk

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

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

Yes No

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

Yes No

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

Yes No

Question 4:

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

Quarterly Bi-Annually Annually Other (outline below)

Frequency is dependent on what is being reported. We felt actual recording will be on going.

Question 5:

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

Advanced communication skills are required – will these be part of the training? We wondered how the public going to be informed of this change? We felt appropriate information should be given to the person in their own words. We were concerned that people may focus on the negative and confidence in the services will suffer. If reporting is out of context this may place a greater risk on the delivery of patient care as people may not come forward. So we wondered how we are going to engage and discuss the expectations of our users? Concern was raised about appropriate information being given to people who may not have asked to be informed of an adverse incident. We were wondering who decides what level of information should be shared. We felt this is especially relevant when people have not requested this information. We felt it was important that information is shared in response to the persons needs.

Question 6a:

Do you agree with the disclosable events that are proposed ?

Yes No

We would like examples to illustrate. The definitions seem clear enough and seem to lean towards the need to disclose only very serious events rather than any event which resulted in harm or had the potential to result in arm. We feel that on balance that it is reasonable to only have to disclose major events.

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

Yes No

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 ?

Comments

Question 8:

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

Comments

Question 9:

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

Comments

Our discussions are captured below – sorry I have not placed in the boxes above

We felt there should be an emphasis on identifying and learning from near misses.

We felt that although definition of harm is outlined within the consultation document more examples as to what adverse harm is in practice with regard to less tangible or obvious areas e.g. psychological damage would be useful.

We felt there should be examples from near misses to adverse harm along a continuous gradient.

We felt that the importance of self management and the patient/ service users/ carer's role in the prevention or notification of adverse harm should be raised.

In response to section 9 we felt examples within a social care setting would be useful.

In response to 9.12 we felt further clarity regarding this with regard to context e.g. is readmission due to lack of self management or as a result in a breakdown in partnership working with the person?

We felt there should be a place to record where people have considered the risks and have opted for a risky intervention as this might be construed as an adverse incident.

In relation to 9.13 we had some discussion and wondered if this is in relation to NHS intervention? Is it attributable to NHS treatment? We felt the need to quantify and place in context. We felt it would be helpful to have examples to illustrate these which reflect all professions within the NHS and social care.

End of Questionnaire