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 ☐

The Picker Institute warmly welcome the Scottish Government's proposals to introduce a statutory duty of candour applicable to organisations providing health and social care in Scotland.

We believe that it is both necessary and desirable to underpin the duty of candour by legislation. Our view is that appropriately drafted legislation will help to facilitate the desired culture of safety, learning and improvement within care providers by ensuring that organisations have clarity and certainty regarding their obligations to disclose instances of patient harm, and by providing a clear legal basis for action in the event that these obligations aren't met. We do not believe that a duty of candour, underpinned only by regulatory requirements or policy guidance, would be as effective as a statutory duty in facilitating this culture.

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 ☐

We agree that it is vital that the duty includes a requirement that staff involved in the incident are appropriately supported and have access to relevant training, information and guidance before, during and after their involvement.

In order for the duty to be as effective as possible in facilitating the desired culture, it is imperative that staff perceive it as a mechanism for fostering openness, trust and organisational accountability rather than as a mechanism for assigning individual blame. Our view is that this can best be achieved by an emphasis on staff support and training in the underpinning legislation.

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

Yes ☐ No ☒

We do not agree that the nature of all disclosures that have taken place should necessarily be *publicly* reported. Whilst we acknowledge the benefits of public transparency and as such accept that there will often be considerable merit to publicly reporting the nature of disclosed adverse incidents, we believe there may be situations in which this may not be appropriate.

In some cases a trade-off will exist between the benefits of public reporting and its costs, for example in terms of its potential impact on public confidence and staff morale. In these cases, a number of different factors may combine to determine whether *public* awareness of the nature of the disclosed incident is in the best interests of all concerned. These factors include for example the severity of the incident, the risk of recurrence and the potential risk of psychological or other harm to the organisation's patients or service users upon learning of the nature of certain disclosed incidents. Therefore we believe there is a risk that a requirement to *publicly* report the nature of *all* disclosed incidents is unnecessarily broad and that more flexibility should exist when determining which disclosed incidents to publicly report.

However, we do agree with the Scottish Government's proposals to require organisations to publicly report the ways in which they've supported staff involved in disclosed incidents and their policies and procedures to support openness, transparency, staff training and development. We believe these requirements, in combination with appropriate reporting of disclosed incidents, will help to facilitate the desired culture of safety, learning and improvement.

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

Yes ☐ No ☒

Whilst we agree that it is desirable in many cases that the person harmed is informed of this harm, we do not believe it is sensible or appropriate to impose a requirement that the person is *always* told about harm that has occurred. As in our response to question 3a, our view is that many factors will combine to determine whether it is in the person's best interests to be informed, including for example: the wishes of the person to be informed; their ability to understand the implications of the information they're given; the severity of the harm; and any potential further impact on the person's health or well-being or psychological harm that could result from being told of the incident, for example resulting from a breakdown in trust or confusion.

We believe therefore that health and social care professionals should be given the freedom to use their professional judgement to determine whether there are extenuating circumstances which suggest it would be in the best interests of the person not to be informed about harm that has occurred. In order to ensure impartiality in these cases, we believe that ideally this decision should not be solely taken by the health or social care

professionals involved in the incident, and that all such decisions should be logged and open to external scrutiny as required.

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

Yes ☒ No ☐

We warmly welcome the inclusion of a requirement to offer reasonable support to the person harmed and to their relatives. However we believe this requirement should also cover those caring for, but who may not be related to, the person who has been harmed.

In addition, we believe the legislation, or associated guidance, should set out the requirements for support in more detail than currently provided in this consultation. For example, it should clarify the different types of support that could be provided to the person, their relatives and carers, in different circumstances and the time period over which this support may reasonably be expected.

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

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

We do not have any comments on this issue.

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

We believe health and care professionals and care providers are best placed to answer this question and therefore we do not make any comments here.

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

Yes ☐ No ☐

We welcome the clarity with which the Scottish Government has sought to define both adverse events resulting in harm and disclosable events.

We believe health and social care professionals and care providers are best placed to comment on the detail of these definitions and therefore we do not make any further comments here.

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

Yes ☐ No ☐

We do not have any comments on this issue.

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

We do not have any comments on this issue.

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?

We do not have any comments on this issue.

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

We endorse the proposal in the consultation to monitor the organisational duty of candour through existing monitoring, regulation and scrutiny arrangements. We agree that embedding the requirements within existing frameworks will be the best way to ensure organisations rapidly become familiar with their new obligations.

We believe care providers are best placed to answer this question and therefore we do not make any further comments here.

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

We believe that the consequences should depend on the nature of the failure to disclose, in particular whether the failure is a one-off event or whether it has occurred a number of times, and whether the failure is the result of inadequate training and knowledge of the duty of candour or deliberate withholding of information.

In order to proportionately penalise organisations given the different reasons for non-compliance, our view is that penalties should be chosen from a range of options, including for example financial sanctions (from fines on a cost recovery basis for less serious breaches to punitive fines for repeated non-compliance) and other remedial regulatory requirements (such as regulatory requirements to raise staff awareness through staff training programmes).

End of Questionnaire