

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 We support this introduction as an important contribution to high quality care, with an emphasis on a person centred approach. To ensure parity, clear arrangements should be put in place to ensure a consistent approach across NHSScotland, as this appears to be a natural extension to the Patient Rights Act.

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

Comments In order to fulfil the obligations of the staff governance standards, staff need to be involved in decisions and to be consulted and engaged on this agenda. Part of this is ensuring that staff have the knowledge and skills to perform their role effectively and therefore they need to be supported in this process and equipped for the difficult conversations that will arise.

It would be helpful for a national education, learning and training package to be introduced (perhaps through our colleagues in NHS Education for Scotland) to ensure a consistent approach to dealing with situations.

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

Yes No

Comments As a public sector organisation we welcome increased transparency in the work we undertake. However, this should not be to the detriment of patient confidentiality, which can be especially relevant in relation to a small area of clinical practice which can easily be connected to a hospital or speciality. Consideration and clear guidance should be given on the level of detail that is made available in the public domain. The media

and members of the public should also be clear on what is or is not released for general consumption.

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

Yes No

Comments

It is vitally important that those involved in communicating have the appropriate written skills (correct tone/phrasing) as well as face to face communication skills.

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

Yes No

Comments In a proposal such as this, it is clear that everyone involved should have a level of support (individualised support depending on need). There needs to be a clear framework on how patients, families and staff members are supported, both by the organisation involved and/or independent third party providers.

We genuinely believe that providing support during this process will aide communication (one of the main reasons for complaints within NHSScotland), and will be more meaningful to those involved. It may help to resolve and reduce the number of complaints raised, as people would be in possession of the facts and circumstances of the incident within a shorter timescale than the current complaint systems allows.

Question 4:

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

Quarterly Bi-Annually Annually Other (outline below)

Comments N/A

Question 5:

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

Comments

- Staff who undertake discussions will need to be appropriately trained and we suggest a multi-disciplinary approach that includes staff with clinical experience as well as those with patient liaison/customer care experience.
- Staff undertaking discussions should also have second tier support from service managers or similar for advice and consistency.
- There should be adequate risk and governance support from staff that have a clinical background and are therefore better able to review the incident and support the staff and person involved.
- There should be education resources available to staff to equip them to deal with difficult situations, and cope with challenging conversations.
- Resources are required for a communication plan to educate and raise awareness for staff, media and the general public.
- General funding towards this initiative would be welcome as it will mean taking frontline staff away from direct patient care in order to have meaningful conversations.

Question 6a:

Do you agree with the disclosable events that are proposed ?

Yes No

Comments We are generally supportive but 'returns to surgery' mentioned in 9.12 may not necessarily be classed as an event or due to reasons of harm so therefore we would welcome stringent criteria on this. In addition, 9.12 needs to be explicit on "unplanned" transfer to intensive care.

It is always difficult to judge if and how an event has had a psychological impact on an individual. More information on this area of the duty would be welcome.

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

Yes No

Comments Some events will be difficult to identify and apply as there may be a host of other related contributory factors in acute underlying disease.

Question 6c:

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

Comments No 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 In our opinion the main issues (some may be in place nationally, others not) are:

- NHS Boards have robust incident reporting systems with an emphasis on real time reporting;
- Clear governance framework;
- Clear timeframes and expectations;
- There is a review/audit process that provides a 'check and balance' to ensure the best process outcome possible;
- There is access to objective clinical opinion;
- Values systems are in place to ensure staff react positively in the circumstances;
- Wide clinical/medical leadership, engagement and involvement;
- Communication training to ensure discussions and written communication is in plain English.

Question 8:

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

Comments The duty should be monitored through Boards' own reporting mechanisms, including Governance Committees and Board meetings that have Non Executive membership. This allows rigorous monitoring while allowing the information to be available in papers that are easily accessible within the public domain. Moreover, it could also be part of the mandatory reporting at NHS Boards' Annual Reviews (also held in public).

Monitoring of guidance and consistency across NHSScotland should be undertaken within set timescales after introduction. One single expert body should be tasked with this (e.g. Scottish Government/Healthcare Improvement Scotland).

Question 9:

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

Comments

Using a checks and balances approach through an incident review system, should mean that organisations can establish for themselves if there have been events that should have been disclosed and learn from any errors.

If the event has not been picked up by the organisation, but from a third party, then an improvement plan should be immediately introduced and

implemented.

End of Questionnaire