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 ☐

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 ☐

Yes - Clarification has to be given as to where the reports will be published and whether they will be reviewed by an independent body before publishing.

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)

Reports should be prepared at the time of the disclosure, but these should be reported on a quarterly basis. It is unclear how these should be made public and whether these should be sent to a monitoring body in advance of the publication to ensure the duty has been adequately fulfilled before public disclosure.

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

Those providing the disclosure will need to be given time to meet with the relevant person and to complete the written work required by the proposals. Suggested templates of reports should be provided to ensure consistent reporting.

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

Yes ☐ No ☐

The levels of harm will need to be clearly defined to ensure they are consistently applied. For example, in England, notifiable safety incidents are defined as those which result in moderate or significant harm. Moderate and significant are also separately defined.

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

Yes ☒ No ☐

If they are clearly defined.

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

The same definitions as above should be used.

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 ?

Clear guidelines as to the level of harm required for disclosure with examples.

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

The duty should be monitored by one body. The registration and monitoring requirements for Independent Health Care Services outlined in the Public Services Reform (Scotland) Act 2010 should be extended to all health care providers in Scotland. The HIS could also adopt the role of the Care Inspectorate, so all health and care services in Scotland are monitored uniformly. HIS should have to undertake inspections of all health and care organisations in Scotland. Therefore consistency will be applied to all services in Scotland. If this is not put in place then careful consideration will have to be given to ensure the duty is consistently applied to all services and the penalties for not fulfilling their duty are uniform to all services, private or NHS.
The standards for independent health care services contained in Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011 should be extended to all NHS services and all requirements contained within these should apply to NHS Boards.
Therefore there will be one set of regulations for all health care services in Scotland.

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

The current penalties under the 2011 regulations for Independent Health Care services should be extended to all NHS boards and Care organisations. Prosecutions should be possible if the duty has not been adequately fulfilled on a repeated basis by one organisation. Extension of the HIS's regulatory powers within the Public Services Reform (Scotland) Act 2010 would enable this.

End of Questionnaire