Health and Social Care

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IHRD Implementation Programme

What does a duty of candour mean for Health and Social Care?

ANALYSIS OF VIEWS FROM INVOLVEMENT EVENTS

(Third edition v2 – Consultation events to November 2020)

Peter McBride

Patricia Donnelly

Claire Fordyce

Alan Weir

IHRD Programme Workstream 1 – Duty of Candour

Personal and Public Involvement (PPI) Involving you, improving care

Health and Social Care

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HSC Health and Social Care

SUMMARY

1 Summary

1.1 Involvement Events

The Inquiry into Hyponatraemia Related Deaths (IHRD) workstream for the Duty of Candour and Being Open subgroup held nine engagement workshops during May and June 2019 to scope the range of views of health and social care (HSC) staff, the third sector and Patient Client Council (PCC) members on the issues involved in developing an open culture across the health and social care system and in the introduction of a statutory duty of candour. Feedback from these initial events was used to inform further involvement events and to guide the workstream on the development of policies for being open and the proposed statutory duty of candour. A further seven sector specific events were held between September – December 2019.

Set out below is a summary of the views from each of the events.

1.2 Being Open

To embed a culture of openness and candour within the health and social care system, feedback from the consultation events would suggest the following key issues need to be addressed:

- **Ensure that mistakes are dealt with in a fair and just way**, and that as far as possible there is a "no-blame" culture.
    - Feedback suggests that the most significant barrier to a genuinely open and candid culture within the health and social care system is fear of the consequences of being open about mistakes.
    - The response to mistakes at the moment is described as defensive and this is seen to work against openness whether that is speaking out about what has happened or speaking openly to service users or carers about it.
    - The current legal advice and managerial direction given when a mistake has been made work against being open and candid.
    - The threat of litigation, disciplinary, reputational and professional damage work against being open and candid.

- **Excellent leadership and management** are seen as key enablers of an open culture, where leaders and managers should be championing openness and candour.
    - It is important that leaders/managers are clear and confident about the appropriate processes to follow when a mistake has happened, and the expectations of openness.
    - It is important that managers, through meaningful supervision, provide support and care to individuals on an ongoing basis to allow for critical reflection on practice, and specifically support when that person has exercised openness.

- The lack of clear, accessible **regional guidelines** on openness is seen as a barrier to openness.

- Feedback would suggest there is a need for clear, simple, accessible, practical regional guidelines for all those involved in the health and social care system about how to exercise openness specifically when something has gone wrong.
- Associated with the introduction of regional guidelines, feedback suggests the need for extensive and ongoing training for staff on how to exercise openness in their day-to-day practice, and specifically when things have gone wrong.
- Training should be comprehensive and extensive, included in professional undergraduate and post-graduate training, at induction and as part of ongoing professional development.
- Based on the regional guidelines, there is a need for clear protocols and procedures to be developed that reflect local requirements.

- **Lack of resources** was seen as a barrier to openness and candour.
  - Not enough time for staff to engage meaningfully with service users to explain what was going on.
  - Not enough time for reflection on practice to learn from mistakes.
  - Not enough time for training and development to provide confidence and clarity about how to exercise openness.

- The importance of **open, honest and compassionate communication** was seen as a key enabler of an open and candid culture.
  - Feedback suggested that communication should be kind and compassionate as well as accurate and appropriate.
  - Communication and information should be proactively given, rather than waiting to be asked.
  - Information should be given by those competent to provide it.

- **Service users and their families/carers should play a central role** in determining how openness is exercised.
  - Service users' rights to information and the importance of consent should take priority in exercising openness.
  - Communication should be proactive, ongoing and two-way.

1.3 Statutory Duty of Candour

- **Organisational statutory duty of candour.**
  - Feedback provided broad support for a statutory organisational duty of candour.
  - Organisations need to have clear policies, guidelines and procedures about candour, and these need to be made easily accessible to staff, service users and the public.
  - Organisations need to provide clear, accessible guidance for individuals working for them on how to exercise candour.

- Mechanisms for supporting staff to exercise candour are required including the provision of appropriate advice and guidance alongside emotional support and reflective supervision.
- Organisations should be proactive and humane in the way they communicate with service users, carers and families both routinely and when something has gone wrong.
- Responsibility for candour should apply throughout the system, with Boards and senior leaders modelling candour, and governance systems in place to ensure compliance.
- Feedback reiterated the important role of service users, families and carers in informing the development of the organisational duty of candour.

- **Individual statutory duty of candour**
  - In principle, there was general support for an individual duty of candour, however feedback reflected significant anxieties about how mistakes are handled currently.
  - Feedback about the individual duty of candour was influenced by views on the existing culture that was characterised by blame, defensiveness and scapegoating. Within this context individuals expressed anxiety about being open and candid because of the consequent fear of being punished or blamed unfairly when something went wrong.
  - Some feedback suggested the review of the current compensation process with consideration of "no-blame compensation" as a way of mitigating some of this threat.
  - Feedback indicated the need for comprehensive training for staff on how to exercise candour, on the premise that the organisation had developed clear, accessible polices, guidelines and procedures for them to follow.
  - Feedback indicated the need for support for staff to exercise their individual duty of candour.
  - Feedback emphasised the importance of listening to service users, their families and carers, and engaging with them in a caring and compassionate way.

- **Criminal Sanctions**
  - Feedback indicated a degree of uncertainty and anxiety about the introduction of criminal sanctions.
  - There was general consensus that in circumstances where organisations or individuals had consistently withheld information, lied, or manipulated information – sanctions were appropriate.
  - There was variation on whether these sanctions should be criminal – some feedback indicated that there were already sanctions in place and that there was no need to add criminal sanctions.
  - There was a view that sanctions needed to be graded according to the severity of the situation.

- There was some feedback to suggest that the introduction of criminal sanctions would:
  - Be counter-productive to creating an open and candid culture.
  - Make Northern Ireland (NI) unique in the United Kingdom (UK), and therefore unattractive for recruitment and retention of staff.
  - Create another level of bureaucracy and fear.
  - Stifle medical innovation and promote the practice of "defensive medicine".

1.4 Feedback on issues specific to the Third Sector

The general feedback above was consistent across all sectors, though dominated by the multiple engagements with the HSC. There were however issues identified in the consultation with the third sector that are specific to it, these include:

- One of the key components of the feedback from the third sector was relates to the perceived power imbalance as a consequence of the commissioning arrangement. This was expressed as the threat of loss of contracts/income when things go wrong, and therefore a disincentive towards candour and openness in light of this threat.
- Feedback reflected the perception that information was not shared openly between the HSC and the third sector, and that communication could be difficult.
- The issue of resources was identified in the feedback as a challenge, with the recognition that greater levels of governance would be required, without the required increases to funding.

1.5 Feedback on issues specific to service users and carers

Feedback from the PCC membership events and the service user and carer event, focused on issues related to a statutory duty of candour in that it was unanimously agreed that it applied to all circumstances when things go wrong. Some also believed it applied to near misses.

Feedback was similar to that from other sectors, however a number of key factors were identified as important for service users.

- Good communication within clinical teams and with service users, carers and families with particular sensitivity in the communication of distressing information.
- Careful use of language and avoidance of jargon.
- Needs of those with mental health issues or dementia.
- Support for those individuals who prefer not to have information.
- Awareness raising with service users, carers and families need to 'know your rights'.
- The involvement of service users, carers and families from the outset and support for this through the provision of advocacy, alongside having clear information and communication.

An overriding message was for candour to be a right that should not need to be requested.

1.6 Feedback on issues specific to the Independent Health and Social Care sector

The general feedback mirrored other sectors feedback in relation to culture, fear, leadership etc. There were however issues specific to this sector which included:

- The need for appropriate regulation for the sector which would support an openness culture.
- The need for a whole system approach which includes the voluntary sector and which is resourced appropriately.
- The involvement of service users and relatives to work towards a climate of openness.

1.7 Feedback on issues specific to Private Healthcare Providers

General feedback was similar to other sectors. The acknowledgement of clear and regular communication to inform the patient's expectations about the service to be provided was referred to within these settings.

1.8 Feedback on issues specific to the Dental sector

The dental sector feedback strongly highlighted the different business model in operation for Practices and the impact this can then have on communication with patients and their experience in these settings. Associated with this, resources were highlighted as a potential barrier and over regulation as a constraint to openness.

1.9 Feedback on issues specific to Social Care Managers

Feedback from this sector mirrored the other sectors. Sector specific issues included the recognition of the commissioner-provider relationship and also strongly advocating for protections and support for staff to institute an open culture.

1.10 Feedback on issues specific to Pharmacy Leads

General feedback was similar to other sectors. This sector highlighted:

- Consistent approach throughout an organisation.
- Improving systems for identifying and disseminating learning.

1.11 Feedback on issues specific to GP Practices

The feedback from this sector strongly highlighted the need to consider the GP Practice setting in providing health and social care as a first point of contact and on-ward referral to wider HSC services. A strong focus was placed on the relationship based care approach with patients, which supports a move towards a more open culture. Specific issues were raised in relation to the size of GP practices and governance or regulation requirements to fulfil the monitoring of such a duty. Further issues were raised

in relation to the threshold level for a duty of candour which created fear, particularly in relation to the level at which potential criminal sanctions would apply. It was highlighted that this could potentially have a detrimental effect in the sector with an increase towards a defensive medicine/risk adverse practice being adopted. The sector also referred to the issues currently in relation to the complaints and SAI process and the impact this creates for an open culture.

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INTRODUCTION

Section 2 **Background to IHRD Programme**

Section 3 **Duty of Candour and Being Open**

Section 4 **Involvement Strategy**

2 Background to the IHRD Programme

On 31 January 2018 the Inquiry into Hyponatraemia Related Deaths (IHRD) was published following an extensive investigation into the deaths of five children in hospitals in Northern Ireland. After hearing evidence from a wide range of individuals and organisations it concluded that four of the five deaths had been avoidable and that the culture of the health service at the time, arrangements in place to ensure the quality of services and behaviour of individuals had contributed to those unnecessary deaths.

In the report Justice O'Hara acknowledged that progress had been made in hyponatraemia practice and guidance but that a more comprehensive approach for learning from error was needed for further unnecessary harm to be avoided. He set out 96 recommendations across 10 themes where he had identified failings in "competency in fluid management, honesty in reporting, professionalism in investigation, focus in leadership and respect for parental involvement".

In developing the recommendations the IHRD report had been guided by five key principles[1]:

1. That healthcare services exist to serve the service user.
2. That the quality of healthcare is dependent upon both clinical and non-clinical services.
3. That the particular needs of children must be addressed.
4. That leadership and candour must be accorded the utmost priority if the fullest learning is to be gained from error.
5. That progress should be subject to regular external review.

3 Duty of Candour and Being Open

At the heart of the 96 IHRD recommendations was for the introduction of a statutory duty of candour and the development of a culture of greater openness in the provision of health and social care services. In his report Justice O'Hara stated that:

"*The unfortunate truth to be drawn from this Inquiry if that here are too many people in the Health Service who place reputation before honesty and avoidance of blame before duty. All that is required is that people be told honestly what has happened and a legally enforceable duty of candour for individuals will not threaten those who conduct is appropriate*."[2]

The Duty of Candour workstream and Being Open subgroup are looking at five recommendations which can summarised as:

a) There should be a duty of candour placed on organisations.
b) There should be a duty of candour placed on individuals and they should be fully supported by the organisations in this.
c) There should be a criminal offence attached to a failure to comply with the statutory duty of candour.

[1] IHRD Report January 2018: Vol 3 Chapter 9 Section 9.1
[2] IHRD Report January 2018: Section 8. 105

d) There should be a change in the culture of the health and social care system towards candour, openness, transparency.

The ultimate goal is to create a more open culture that will transform the experience of service users, carers and families in the future.

4 IHRD Workstream on Duty of Candour and Being Open subgroup – Involvement Strategy

The workstream is applying the principles of openness and honesty to its own work.

It recently published a series of research papers that it commissioned to help understand how candour is applied in other parts of the world. Earlier this year the Duty of Candour workstream asked for individuals and organisations to submit any evidence or research they have about introducing a statutory duty of candour and what it might involve and received twelve written submissions, predominantly from health and social care representative bodies. This information is all available to view at https://www.health-ni.gov.uk/articles/ihrd-get-involved-duty-candour

It is essential that the widest range of individuals and organisations have the opportunity to express their views on a duty of candour and as part of this process the workstream held a series of involvement workshops with stakeholders during the months of May to June and September through to December 2019. Feedback from the initial events helped to inform the later events, particularly for service user and carer involvement.

The detail of these engagements and their outcomes is set in the appendices to this paper. The sections that follow are summaries and analysis of the engagement events in respect of views on how to create an open culture in health and social care organisations and on the recommendations for individual and organisational duty of candour.

Detailed feedback from individual engagement events is set out in the separate Appendices Document: REF xxx Section 1 - Appendices 1 to 7 with detailed Word Clouds representing the most frequently mentioned words and phrases set out in Section 2 – Appendices 1 to 9. The response by individual stakeholder groups are summarised with commentary in the sections below.

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5 BEING OPEN

Sections 5.1	**HSC staff views**
Section 5.2	**Third sector views**
Section 5.3	**Independent Health and Social Care views**
Section 5.4	**Private Healthcare providers views**
Section 5.5	**Service user and carer views**
Section 5.6	**Dental sector views**
Section 5.7	**Social Care Managers views**
Section 5.8	**Pharmacy Leads views**
Section 5.9	**G.P. Practice views**

5 Being Open

In considering the issues around the development of a more open culture in health and social care services the stakeholder groups were asked a number of questions about what this looked like, the barriers to its development and how these could be overcome.

5.1 HSC staff views on Being Open

a. HSC Staff - For the question on "What does an open organisation look like for staff?" a number of key characteristics were identified.

Developing a "No Blame" Culture

When asked to describe the characteristics of an "open organisation", staff described one in which there was no fear associated with making mistakes, where in fact making mistakes was accepted as a normal part of working life, and in which openness about these was expected and incentivised.

They described this as **the absence of fear of formal or legal consequences** – examples of this were the absence of the fear of litigation and formal individual sanctions relating to both professional registration where applicable, and job security.

There was the acknowledgement of the need for the organisation to be "just", and the recognition that mistakes would happen, however there was an aspiration that organisational responsibility would transcend individual responsibility when mistakes happened, and that as a result, individuals would not unreasonably be exposed to individual blame or personal reputational damage.

Ensuring there is a Learning Culture

There was a clear linkage in staff's mind between openness and how mistakes were managed, with a strong focus on the need to have a **learning culture in which mistakes were seen as an opportunity to learn lessons and improve services for both individuals and teams.**

The formal mechanisms for learning were seen as important, with the need for the opportunity to honestly reflect on personal and team practice as a key component. This was articulated in a desire for more structured, protected time for reflective supervision, education and ongoing professional development; with the expectation of capturing the learning at an organisational level and sharing it regionally.

The importance of Supportive Management and Leadership

Leadership was seen by staff as a critical component of an open organisation, **with leaders both supporting staff to be open as well as modelling openness themselves**. Supporting openness was seen as leaders having a good working knowledge of the openness policies and procedures, following them themselves when they made mistakes and supporting staff to do likewise.

Collective leadership was seen as a positive expression of this, and there was an aspiration towards flatter, less hierarchical, management structures with **more emphasis on team rather than individual responsibility, and less boundaries between teams and departments**. The personal characteristics of openness, approachability and personal reflectiveness were seen as critical to good leadership in an open organisation.

The importance of Structure and Processes

Alongside the personal characteristics associated with individuals within an open organisation, there was the recognition by staff of the need for clear guidance in the form of policies and procedures.

Clarity, simplicity and consistency within organisations, and at a regional level, were seen as the key components of openness guidance, with clarity about responsibility for managing the process both locally and regionally. There was also the expectation that policies and procedures would be service user centred and based on Trust Core Values, with staff appropriately inducted, trained, resourced and supported to follow them.

The importance of Open Communication

Staff made a clear link between an open organisation and high levels of good quality communication. The quality of the communication was described as honest, accessible, trustworthy and based on good collegial and managerial relationships.

The listening component of communication was emphasised, with a clear challenge to listen both to the needs of staff and to the concerns of service users**.**

Structured opportunities for both of these groups to easily identify concerns and receive **feedback** were seen as extremely important, as was the need to make it easy to raise even the smallest concerns whether as a staff member or as a service user/carer.

b. HSC staff - In response to the questions "What does an open organisation look like from a service user/carer perspective?" the following characteristics were identified.

The importance of Honest Communication

The key component of an open organisation for service users/carers, from a staff perspective, was honesty - that **service users/carers would be told the truth in a way that was understandable to them and with kindness and compassion**.

There was recognition of the importance of identifying the information that was important to service users/carers, and the need to ensure that their questions were respected, validated and answered.

It was also recognised that it was important the person answering the questions was qualified and competent to do so. As well as answering questions from service users/carers honestly, competently and openly, it was also recognised that it was important to be open to a **two-way, ongoing conversation** with service users/carers, responding to feedback from them and ensuring that they do not feel that information is being withheld.

The importance of Personable Communication

As well as the need to have open honest communication, staff recognised that the way information was communicated was also important. There was the acknowledgement that **communication needed to be offered in a way that was caring, compassionate, kind and responsive to individual needs; not defensive or intimidating.**

There was also the recognition that from a practical perspective, there needed to be enough time and space given to meaningful communication, with face to face contact with consistent individuals who could support service users/carers through the feedback process over time. If it was appropriate, staff also recognised the **power of giving an honest apology**, and the importance of this to service users/carers.

The importance of Accessible Systems

The importance of ease of access to information was identified by staff as a key component of an open organisation, with service users/carers having open access to relevant paperwork and information.

Ease of access also meant the **freedom to speak up, ask questions** and receive clear explanations in an understandable, timely way for service users and their families/carers.

Clarity with service users/carers about **organisational processes** and how to navigate them was also identified as important, as was the importance of not using jargon and recognising that the language used might be different for different individual's needs.

The importance of Clear Processes

Staff identified that in an open organisation, **service users/carers should receive information and feedback proactively,** not just when they asked for it, with the expectation of their continuing active involvement throughout the process.

They should expect to be engaged early if something has happened, and be actively involved in the process with time and support available to ensure that they understand and can contribute in a meaningful way, with staff appropriately qualified to answer their questions and lead them through clearly described and organised processes.

c. **HSC staff - The question on "What are the obstacles/barriers to being open?" elicited a range of responses.**

Fear

Fear of the consequences of being open was presented by staff as the biggest hurdle to an open organisation, and the fears can be categorised as follows:

- **Fear of legal consequences** – these included the fear of litigation and fear of criminal investigations.
- **Fear of professional consequences** – these included the fear of investigation and sanction by professional bodies with the threat of loss of professional registration.
- **Fear of employment consequences** – these included the fear of disciplinary action that might lead to dismissal.
- **Fear of reputational consequences** – these included the stigma and shame associated with making a mistake or causing harm and the possible loss of professional reputation. This also included fear of the social media response and other public media responses.
- Alongside these specific fears, staff also identified a **lack of trust in the existing system** as an obstacle to openness – specifically the fear of being unfairly scapegoated as a consequence of being open about an incident. Staff also articulated the challenges of working closely in a team, and not wanting either to let the other team members down or get them into trouble if a mistake has happened.

Lack of resource

Lack of resource was identified by staff as a significant hurdle to an open organisation both in terms of having the time and resource to complete the required administration, and the necessary skills and training.

- **Need for clear processes**
  Staff identified inconsistent processes across organisations in relation to reporting mistakes and openness, and that this was a barrier to openness. There was a view that current processes, IT recording systems and administrative practices did not facilitate openness and that **there was a need for a consistent, streamlined regional approach**. In relation to the issuing of **apologies**, over-reliance on medical approval for releasing information, the adversarial nature of the clinical negligence investigation process and the consequent anxiety that an apology is seen as an admission of guilt all were barriers to openness.
- **The importance of leadership and management**
  Staff expressed a view that poor leadership and management were barriers to open organisations, with lack of support, overly hierarchical structures, professional protectionism and the absence of regular supervision cited as factors that can lead to a lack of trust and a consequent lack of openness.
- **The relationship between openness and confidentiality**

There was recognition from staff that one of the barriers to openness was the practical challenge of operating in an open environment while being **respectful and aware of the rights to confidentiality, the determination of capacity and the importance of consent.**

d. **Ideas came forward in response to the question of "How can we overcome the obstacles to ensure that we have a climate of openness?" which highlighted the key processes.**

The importance of policy, processes and guidance

Staff identified the need for **clear, simple, accessible regional guidelines for being open, that were distinct from, but connected to other processes for investigation, learning or legal involvement.** Associated with this guidance, staff articulated the need for support and training in the use of these guidelines, starting with induction, and incorporated into the dissemination of the core values of the organisation. There was also the recognition that adherence to these guidelines would require time and resource.

Staff identified the importance of **aligning openness guidelines** with other organisational policies and procedures, specifically where there was the possibility of legal involvement, and there was acknowledgement that the introduction of legal sanctions could cause the unintended consequence of less openness.

In relation to the **legal context,** staff articulated the importance of aligning the organisation's legal advice, to ensure that this advice did not, inappropriately, **work against the principles of openness**.

Staff identified the important role of **families and carers** in the development and successful implementation of procedures for openness, and the importance of having a clear structured system for service user/family/carer involvement. The benefit of external involvement was also identified by staff for example the possibility of external investigators for Serious Adverse Incidents (SAIs) and the role of community advocates.

Staff also reiterated the importance of managing the external facing component of openness, both in terms of **managing communication** with the general public and managing the media.

The importance of Training and Supervision

Staff made a clear correlation between the successful development of a culture of openness with the provision of comprehensive training, support and supervision. **The scope of the formal training should be comprehensive, covering induction, under-graduate and post-graduate training, professional training and professional development training**.

There was also the recognition of the importance of less formal training opportunities through team learning events such as learning lunches and multi-disciplinary sessions. **Supervision, clinical and managerial, was identified as a key enabler to overcome the barriers to an open organisation** as a

context in which staff could reflect on their practice, learn from mistakes and become more familiar with the application of policies and procedures.

Staff also made a distinction between the training required to follow the guidelines, and the training required to engage appropriately with colleagues and service users, for example training in managing difficult conversations and interpersonal skills training.

The importance of leadership and management

Excellent leadership and management were seen by staff as essential in creating a climate of openness and overcoming the barriers they had identified. This was both in terms of role modelling good practice in openness and facilitating openness through their managerial and leadership practices.

The key leadership components identified by staff were accessibility i.e. open-door policies and high levels of visibility; structured engagement opportunities i.e. monthly focus meetings and high-level reviews; and supportive practices i.e. recognising if staff are experiencing abuse, under pressure or becoming unwell. There was also the reminder of the importance of leaders celebrating the successes of staff.

The important role of service users/carers

Staff reiterated the importance of involving service users/carers/families in the development of open organisations, creating formal and informal structures through which they can have an input.

Early engagement was emphasised as important as was the need for a personal approach and encouragement for engagement both when a mistake has happened as well as routinely in the development and improvement of services.

Beyond the importance of engaging directly with service users, their carers and families, staff highlighted the importance of measures to engage meaningfully with the general public, ensuring they understood the pressures the system may be experiencing and managing their expectations. **Co-production and community advocacy** were also mentioned as examples of mechanisms that could be used to engage more broadly.

5.2 Third Sector views on Being Open[3]

a. What does being open look like?

Attendees thought 'being open' was providing information at a level that is **understandable** to the person receiving the information. **Transparency, proper record-keeping and full disclosure** without deceit or concealment were all considered traits of a 'being open' culture. Also important, it was

[3] Summary of feedback from the third sector events provided by NICVA

argued, was informing the client/service user why the organisation was asking for certain information and what it was doing with that information.

Attendees also thought that **clear policies and procedures should** be implanted to enable a culture of 'being open'. One example was creating a clear policy disallowing the amendment of meeting minutes. Other attendees thought a negative implication of new General Data Protection Regulations (GDPR) can lead to organisations not being truthful or open, and GDPR must be taken into consideration within a culture of 'being open'.

A 'being open' culture is also characterised by a **removal of fear of repercussion** for whistle-blowers and no 'cover-up' mentality should things go wrong.

Many attendees wanted the **limits and capacity of the voluntary and community sector to be taken into consideration.** Attendees noted that small organisations delivering health and social care may not have the same capacity as larger organisations to spend the time explaining complex detail to service users, suggesting that time spent adhering to new 'being open' policies is time not spent delivering care. It was argued that voluntary and community organisations already work in a 'being open' culture.

At the second event, attendees stressed that achieving a culture of being open required there to be a **lack of fear or threat of the consequences of being open** and that people must feel allowed to be open.

Some participants felt that being open was **embedded and natural in the voluntary and community sector** while others said that it was still important to work with staff to **create and model a culture of openness.**

Attendees also stressed the need for voluntary and community sector organisations to be able to easily **access relevant and quality information**, and not have unnecessary barriers put in the way, such as GDPR when in fact it does not apply. It was suggested there needs to be more training on this latter issue. The need for an effective two-way flow of information between the voluntary and community sector (VCS) and statutory sector was also stressed.

Other points stressed by attendees included the importance of an effective and open system that ensured that the VCS sector's work and contribution was valued, acknowledged and respected; and also that there was consistency in the delivery of care by consistent health professionals throughout the care process.

b. What are the benefits of a culture of 'being open'?

Overwhelmingly, attendees thought that 'being open' inspires **confidence**, effectiveness, efficiency and **trust in** the system, the care being delivered, and those delivering the care: the client/service user will feel empowered and valued, their needs understood, and those delivering care can benefit from increased confidence and morale in their roles. **Continuous service improvement** through learning was also seen as a benefit to a 'being open' culture.

An organisation 'being open' also benefits from **increased accountability**, safety and quality. Any mistakes will be accurately recorded and learned from.

A common benefit of 'being open' attendees argue, is ultimately **better outcomes** for clients and service users. This was reinforced at the second event where participants felt it would result in better outcomes for patients, who would be more engaged, more informed, and feel more of a lead partner in their own care. It was also felt that a culture of being open would encourage greater levels of trust by users in the health services they receive, and between service providers and their staff.

Attendees at the second event stressed that a culture of being open would encourage a **more consistent and joined-up approach** across VCS and statutory services, including stronger and easier referral pathways as well as a reduction in inappropriate referrals.

Attendees also felt it would provide a foundation for providing support throughout organisations, especially to staff, and would also encourage learning, growing and responsive organisations with better change and risk management processes.

c. What are the challenges to 'being open'?

Attendees overwhelmingly thought, for an individual, a **fear of blame** and a possibility of others' perceptions, of litigation or even losing their job was a challenge to having a culture of 'being open'. For organisations, there was a fear losing contracts, funding and, ultimately, **reputational damage**. Understanding and taking into consideration the diverse needs of the client/service user was also considered a challenge to creating an open culture – if, for example, the client/service user had a mental health or other condition limiting their capacity to make decisions.

Attendees also felt the current **resources given to the VCS** do not equip organisations to provide the training and support necessary to cultivating a culture of increased openness. Some attendees cited a **power imbalance** characterised by a lack of respect shown by statutory sector contract managers toward the voluntary and community sector. It was argued that the skills and professionalism of the voluntary and community sector was not understood or, at worst, not respected.

An element of cynicism did exist among attendees. Some queried if the process was mere tokenism and questioned if the changes would be implemented in the wider system.

Attendees at the second event identified key challenges which included the fear of repercussions for speaking out and reluctance to deliver difficult information to or inform on service users; resistance to culture change and a lack of buy-in from leadership; and constraints on time, resources, staffing, and support to staff.

Other challenges raised included underestimating the capacity of patients to speak for themselves and underestimating the professionalism and standards of voluntary sector providers.

Attendees also highlighted as barriers to being open: the level of understanding of GDPR amongst health professionals; relationships within and viewpoints of Multi-Disciplinary Teams and the

tensions between meeting contractual challenges versus taking the viewpoint of the best interests of the patient.

d. How can we overcome the challenges to 'being open'?

Providing appropriate, **targeted and specific training** was the most common suggestion to overcome the challenges to 'being open'. It was also suggested that a significant investment in resources, leadership and development was required, along with a strategic review of policies and procedures. One suggestion was a **strategy to empower people** who may otherwise be unable to raise issues or express concerns, especially clients/service users who rely on non-verbal communication.

Attendees also thought that **greater accountability** and checks and balances on those in positions of power. One suggestion was the creation of an independent body, described as a '**Department of Candour'**, to perform this function.

Many thought challenges to 'being open' could be overcome by **learning from other jurisdictions**. One suggestion was implementing something similar to the '**Freedom to Speak Up Guardian'** roles currently implemented by the Care Quality Commission (CQC) in England.

At the second event, attendees suggested there needed to be **investment** in terms of money, time, staff training and support, developing procedures, and reconfiguring systems. They also stressed the need for cultural shift and suggested organisations could undertake honest baseline assessments of the culture of their organisations. They also highlighted the need for leadership, and for leaders within the system to be both actively involved and accountable through mechanisms for staff feedback.

The importance of clarity and using clear **language** in relation to the concepts being discussed was also stressed, as well as the importance of having a clear definition of what partnership between the statutory and voluntary sectors means.

Other points raised were the need to have openness working in tandem with necessary confidentiality and the need to consider whether providing certain information could put someone at risk e.g. in cases of domestic violence/safeguarding of children and vulnerable people.

5.3 Independent Health and Social Care views on Being Open

a. What does being open look like?

Attendees thought 'being open' in the independent health and social care sector centred around **culture** in relation to the absence of blame or fear, the acknowledgement when things have not gone right and about having a partnership or co-production approach. This was closely associated with **leadership and management,** where there is a clear vision and managers are visible and approachable. Leaders are required across the organisation and communication is required up and down the organisation structure.

Regulation was referred to as having appropriate regulation and that inspections should not restrict openness. The relationship with regulators was referred to as one which should be positive to support confidence.

A number of areas were identified to **support** an open culture which included clear guidance and understanding of processes and procedure and clear language. Staff support in relation to meetings and effective communication via newsletters, good induction process and a listening culture.

b. What does an open organisation look like from a service user/carer perspective?

Attendees referred to an organisation where there is an **honest relationship** and one who involves families when something has gone wrong. Having **clear processes** for making a complaint and providing guidance and honest two-way communication. Ultimately an organisation where concerns are raised, then these are acted on and change is the result.

c. What are the barriers to openness or an open culture?

I. **Nature of regulation**
Regulation was identified as a hurdle where there was a heavy-handed/ inappropriate and one-size fits all approach. Attendee's referred to the lack of joint working between providers and regulators and a paternalistic approach.

II. **Fear**
Fear of the consequences of being open related to organisational level including damage to reputation, media response etc. Fear was also cited at an individual staff level as disproportionate disciplinary actions, fear of blame, losing job and speaking out.

III. **System**
The absence of a whole system approach was referred to and the voluntary sector being undervalued by the Trusts. Resourcing constraints which impact on the time to spend with clients can work against the ethos of the care sector.

IV. **Leadership and relationships**
Lack of management skills and leadership was identified alongside the existence of a blame culture. A lack of communication and disengaged staff didn't support the development of relationships.

V. **Media**
Attendees referred to the media and a fear of bad press alongside the lack of good news stories related to the sector.

VI. **Legal**
Issues surrounding case law and an apology being an admission of guilt were identified. Alongside this, relatives with high expectations and litigation were also cited as barriers.

d. How can we overcome the obstacles to ensure that we have a climate of openness?

Contracting and regulation were identified by staff and in particular the need for joint working to create an open culture with a focus on improvement rather than regulation. A consistent approach to reporting and oversight with a greater authority for providers to operate the safeguarding

process. Better contracts based on care, rather than budgets was highlighted. The need to challenge the perception that home owners were hiding issues was also identified.

Attendee's identified that **service users and relatives** have a role to play in creating a climate of openness. This includes having open conversations to discuss and manage expectations alongside being involved in planning decisions. Patient responsibility and also sanctions to family members were identified.

The need for **Leadership and Management** was identified. This included leading by example and having trust in the whistle blowing policies. A better use of resources and staffing ratios were also identified by staff as barriers.

5.4 Private Healthcare providers views on Being Open

a. What does an open organisation look liked for the Private Healthcare sector?

In their feedback staff emphasised the importance of **communication and leadership**, which will allow openness to work in practice and make it easier for everyone to report concerns throughout the organisation. They identified that an open culture will be possible where there is **accountability**, and **actions** are taken, to address issues when things go wrong and investigations are undertaken. It was also strongly felt that **staff** had to be engaged in these processes, in order to allow them to feel that they are being listened to when concerns are reported.

b. What does an open organisation look like from a patient/ carer perspective?

Private Healthcare providers felt that patients and carers had an expectation of **different standards** in a private setting. They said that an open organisation would have **clear** and **regular communication** to inform patients' expectations about the service that is being provided and are therefore aware of the processes involved.

c. What are the obstacles/barriers 'being open'?

Private Healthcare providers mentioned **fear** of **reputational risk** and **personal liability** as key barriers to being open. In this context, the **absence of feedback** or **poor communication** were seen as added factors that contribute to that fear, in a high-pressured environment with **targets** to meet and **resource** pressures. In this environment, the **appetite for bad news** and the difficulty representing health care services in a positive light were additional obstacles to being open about performance.

d. How can we overcome the obstacles to ensure that we have a climate of openness?

Feedback indicated that **improving communication** with staff, **welcoming feedback**, and **learning** from incidents were ways in which openness could be achieved. It was suggested that organisations that **demonstrate openness**, particularly amongst their **leaders** and **senior managers**, were more likely to implement openness successfully. Systems such as

whistleblowing were also suggested as mechanisms which would successfully implement openness and **reduce blame**.

5.5 Service user and carer views on Being Open

a. What are the key elements of a being open organisation from a service user or carer perspective?

Feedback indicated that **good communication skills**, which demonstrate that staff are actively listening to, and are empathetic towards, service users and carers, is a key element of an open organisation. It was felt that staff with these skills demonstrate the key **values** of an open organisation, namely compassion and empathy.

Feedback also highlighted that **involving** patients, service users, carers and their families from the outset and throughout was an important attribute of an open organisation. Working in **partnership** to deliver care was also identified as a key element of being open.

Two key actions identified through feedback were a **mystery shopper** approach to gauge openness, and dedicated time and resources for **reflective practice** for staff to improve openness.

b. What would this look like i.e. how would you know this is in place?

Attendees suggested that continuous **communication** would enable both sides to feel valued as part of the process, and that promoting **involvement** would reinforce this feeling. Specific actions identified to implement openness in an organisation included:

- Advocacy services.
- Involving service users in the training of staff.
- Public meetings between leaders and the public.
- The use of plain English.
- Training.
- Independent monitoring of openness.

c. What support do people need?

Feedback clearly emphasised the importance of fully **independent advocacy support** to assist patients navigating processes and procedures. It was also suggested that clarity needed to be provided about who was responsible for these services and in which settings. Another key support mechanism identified within feedback was the provision of **emotional support** for patients, particularly when they are receiving bad news.

5.6 Dental sector views on Being Open

a. What does an open organisation look like for staff?

Attendees referred to **communication** and the confidence to speak up at any level, regardless of hierarchy or consequences. Feedback was also referred to as being important.

The **culture** of the organisation was referred to in relation to having visible/accessible and approachable management. A non-hierarchical structure was identified with all contributions valued and where learning is encouraged.

Having regular meetings and staff appraisals alongside having **protected time for training and reflective practice,** were all identified as being key elements of an open organisation.

The **routine practice of involving patients** was referred to.

Participants referred to the **difficulties which exist through the nature of the smaller dental practice setting** and the business model. This included having no hiding place and also the perception of how this will be viewed from other dental practices.

b. Put yourself in the shoes of the patient and consider does this change your view?

Participants identified **patient experience** in relation to spending time with patients, providing an environment where people can ask questions and be informed about treatment options. Patients are aware of the complaints system and an assurance that if a concern is raised that they are listened to and it is taken seriously.

The provision of a **two-way flow of information** was identified where information is available and actively given to patients, who then have an opportunity to provide feedback or speak to someone.

c. What are the barriers to openness or an open culture?

Respondents identified **resources,** such as time and training as barriers and highlighted that dental practices are a business and privately owned practices. Having the time to fully explain procedures was also identified which was related to cost allocation based on the current business model. Punishment was also identified in relation to financial or powers to restrict or close down practices. A lack of support for indemnity was also identified.

Fear of the consequences of being open was raised in relation to regulation, General Dental Council (GDC), legal action, litigation, punishment etc.

Culture was also raised as a barrier, including defensive hierarchies, difficulties with raising issues with principal dentist and relationship issues in small practices. **Over-regulation** was also identified as a constraint rather than supporting a culture change. Absence of protections for making an apology was also raised.

Managing the expectations of patients and also **language barriers** exist with access to translation and interpretation services sometimes being difficult to ensure patients have a full explanation of treatment.

d. How could these be overcome?

The importance of **resources** was identified in relation to a better funded system to allow time to communicate with patients and reconsider the remuneration model to reflect time rather than outputs.

The need to consider **regulation** was also raised to remove the punishment and blame culture.

Providing support for patients included access to interpreters and having a clear pathway for patients to raise questions.

Staff support was identified in relation to individual appraisals and engaging Northern Ireland Medical and Dental Training Agency (NIMDTA) to support the appraisal system.

5.7 Social Care Managers views on Being Open

a. What does an open organisation look like for staff?

Respondents felt that an open organisation focused on **accountability** rather than having a "blame culture", in order to learn and improve as a result of mistakes. The importance of **senior leadership** on this issue was also emphasised, in order to allow staff to feel that there was an equal playing field to raise concerns and that they had support from their organisation to speak up. It was noted that an open organisation would be in line with the value-led, value-based approach to practice in social care.

b. What are the barriers to openness or an open culture?

Feedback identified a number a barriers to openness, including the **hierarchical system** and pressure on **resources**. In social care, the added dynamic of the commissioner / provider relationship was identified as another barrier which was relevant to that sector. Blame culture within systems or organisations was another key theme which emerged during feedback, which may lead to fear of punitive reactions to being open or subsequent litigation if staff speak out when things go wrong.

c. How could these be overcome?

Respondents identified the importance of **protections and support** for staff in order to institute an open culture. Initiatives suggested included clear guidance, advocacy schemes, openness champions, leadership, and protection for making apologies. It was also recognised that the introduction of an open culture would require additional resources, time and structural changes.

5.8 Pharmacy Leads views on Being Open

a. What does an open and candid organisation look like?

Feedback suggested that a **consistent** approach throughout an organisation is key to implementing openness. It was suggested that open organisations implement a **just culture,** using an **objective**

and **proportionate** approach to investigating mistakes which does not seek to apportion blame. The value of **leadership** at all levels was also recognised, in order to demonstrate the **value** of openness to the organisation.

b. What are the barriers to being open and candour?

The feedback identified a number of barriers to openness, including the **culture** of an organisation, the lack of **resources** available to the system, and **bureaucracy** that can often slow down the responsiveness when things go wrong. These barriers can often limit the time available to be open, and undermine confidence amongst staff, creating a defensive and unresponsive culture.

Other barriers identified included: understanding; negative media coverage; professional rivalry; fear of prosecution for dispensing errors; lack of insight; and confidence in whistleblowing procedures.

c. How can these barriers be overcome?

Feedback provided a variety of solutions which indicated the need to improve the system in place for identifying and disseminating **learning**. Attendees also suggested that clear processes, accompanied by appropriate **supports** for staff, would improve openness. Some of the solutions identified to improve openness included **training** initiatives, reflective practice, SQE programmes, professional development programmes, and protections for staff.

5.9 G.P. Practice views on Being Open

a. What does openness look like within your GP Practice?

Openness was described as the **culture within GP Practices** for all staff. This is seen as an organisation who provides training and learning when something has gone, where concerns can be raised with colleagues and action can be taken when required. GP's referred to openness being a central part of their practice to embed the learning rather than blame culture for all staff.

The **development of relationships** with patients was referred to as an integral part of an open system. This included actively involving patients in a joint decision making process where clear communication and support is provided to help navigate Health and Social Care as they are often the first point of contact into the System. Feedback is also encouraged on a one-to-one basis and Patient Groups were also referred to.

Governance arrangements were also referred to, which included having audit, risk management processes etc. in place. The importance of incident reporting systems was also identified to ensure learning structures are in place to continually review an improve practice which can happen very quickly due to the nature of the smaller Practice settings compared to larger organisations.

b. Put yourself in the shoes of a patient and consider does this change your view?

Participants described openness for patients as being listened to, understanding their concerns, accessing advice, providing and exploring options and being honest and realistic about what can be achieved. The **relationship based approach** was also referred to in relation to developing a connection with patients, ensuring shared decision making and also working with patients at where they are at which results in a good experience.

c. What are the barriers to an open culture within GP Practice settings?

The following barriers were raised:

- **Time** in relation to the lack of protected time to review and discuss all concerns, Long waiting lists create pressures on GP Practices to manage patients. Long working hours was also raised.
- A **blame culture** in relation to a fear of repercussions, being threatened, criminal sanctions being imposed. It was also raised that it can be difficult to raise concerns within Practice settings and across different Practices.
- Current complaints system can be time consuming and emotional exhausting and the impact of the involvement of the Ombudsman in certain cases.
- The size of GP Practices and associated governance responsibilities compared to larger HSC organisations was referred to.

d. How could these be overcome?

Participants identified a number of ways to overcome the barriers of openness:

- Embed an openness culture. This is for both patients and all GP Practice staff to provide a supportive environment within Practices for issues to be raised and addressed within a no blame/learning first culture.
- An understanding of openness from a patient perspective and an awareness that things go wrong and when this happens learning will be put in place. Good communication and managing expectations are also important.
- Resources in relation to funding, having protected time to discuss issues with colleagues and on-going training.

Health and Social Care

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6 Duty of Candour

In considering a statutory duty of candour the stakeholder groups were asked to respond to number of case studies and identify issues to be considered by the workstream.

6.1 Patient and Client Council member views on Duty of Candour

a. PCC CASE STUDIES –From the case studies provided PCC members identified where a duty of candour should apply and circumstances that need to be considered

In their feedback on the case studies presented PCC membership group identified the key issues in relation to a duty of candour.

i. From the cases discussed PCC members believed that a duty of candour applies in most circumstances and in **all circumstances when something had gone** wrong.
ii. Some PCC members believed a duty of candour also applies to '**near misses'.**
iii. They recognised that there were circumstances when the **anonymity** of individuals needed to be protected where there were child welfare concerns.
iv. Cognisance needed to be taken of **individual's preferences** if did not wish to receive information, particularly those with mental health issues or dementia etc.
v. **Communication** was identified as a crucial – within clinical teams and with service users, carers and families.
vi. **Sensitivity** was needed in communicating distressing information.
vii. **Advocacy** and support for families was highly valued.
viii. No blame culture for staff.

b. PCC members views on obstacles/barriers to a duty of candour

The PCC membership group identified a number of barriers to being candid and suggested ways in which these could be addressed.

i. Fear of **litigation and reputational damage**, including staff members fear of incriminating themselves and the repercussions of doing so. Training was proposed as means of promoting openness and candour with staff needing support and protection to exercise their responsibilities.
ii. **Poor communication** with service users and families was identified as problematic with the need to take time to communicate in a sensitive and compassionate way without jargon. A particular issue was identified where staff used GDPR requirements as a rationale for not being open.
iii. **Blame culture** was an issue needing to be tackled through tracking the chain of responsibility and focus on the learning outcomes.

iv. Staff issues were identified, in particular with agency staff who are less familiar with the patients or systems. The biggest concern was the culture **of 'the doctor is always right'.**
v. **Support and advocacy** needed to be provided for service users who preferred to have less or no information with individuals having better awareness of their rights to information.
vi. **Leadership** was identified as essential in achieving a 'top down' change.

c. PCC membership views on what questions to ask the public to inform the work on a duty of candour

When considering what questions might be used in future involvement events the PCC members identified a number of areas and made some general comments.

i. Knowledge/ **awareness** on how to get information needs to be developed further and more accessible and people should be asked for preferences.
ii. Circumstances where individuals would prefer not to have information should be explored further, particularly where **advocates** might have a role.
iii. The public should be asked direct questions on whether individuals **support a duty of** candour.
iv. Other comments included the need for health and social care system to l**earn from mistakes** in a more timely way.
v. The role of **apologies** in a duty of candour should be developed.
vi. A 'no blame' culture essential for **staff buying into** a duty of candour.
vii. Staff listening to the experience of service users, carers and families and to be clear about whose 'best interests' are being served.

6.2 HSC Staff views on Duty of Candour

a. HSC CASE STUDIES: Under a statutory duty of candour, who would you expect to be told and why, or why not?

Who should be told?

While each of the case studies was different, there was consensus that, in most circumstances, a wide range of people might be told what had happened, unless there was a clinical or other reason not to. These can be categorised as:

- **The service user and their immediate family/carers** – the issues identified with this group were about the service user's capacity and best interests, and where there was the possibility of speaking with the service user's family, carers or next of kin the issues were about clarity around who was entitled to know i.e. who was next of kin, or who

had power of attorney; and the service user's capacity to give consent for information to be shared.

- **Health Service Professionals** – where there had been an adverse incident, or harm had been caused it was clear that there were responsibilities to inform other healthcare professionals involved with the care of the service user, as well as follow the organisational reporting requirements.
- **External bodies** – depending on the nature of the incident, it was also acknowledged that external bodies may need to be informed i.e. regulators, professional registration bodies and potentially the Police Service of Northern Ireland (PSNI).

The mechanism for telling

There was agreement that depending on the nature of the event, it was important to have clarity about the appropriate process for disclosure. It was clear that there are systems currently in place such as SAI reporting, and others were mentioned such as DATIX, mortality and morbidity meetings and IR1 reporting. There was also the recognition that in severe cases, there was the need to report to legal bodies and the PSNI.

What informs the decision to tell or not to tell?

There was recognition that the general principles of openness and candour apply at all times, but there may be factors that would result in individuals not being told what had happened. Staff identified the importance of clarity about who has a right to give consent for information to be shared. This is complicated by issues around the capacity of the service user to provide informed consent, and the rights associated with service user/doctor confidentiality. Staff also affirmed the importance of clarity about who was responsible and accountable for making decisions about who should be told, and the process and required consultation by which those decisions are made. This challenge is made all the more complex when dealing with children, or people with communication difficulties.

b. HSC CASE STUDIES: Consider the different levels for a duty of candour, and consider why or not it would apply to the following?

Statutory organisational duty of candour

Staff identified the importance of clear organisational policies and procedures for the duty of candour, and that the organisation had a responsibility to ensure these were clear, ensure staff were aware and trained to exercise candour, and ensure ongoing support for its continued application. It was also made clear that the organisation had responsibility to ensure that outside bodies were involved where appropriate, as well as responsibility for engaging any legal processes. The organisational duty of candour was seen to put the organisation under a statutory responsibility to provide clear guidance, appropriate support, transparent accountability and governance; and to take responsibility for any systemic challenges within which people were working.

Statutory individual duty of candour

Within the context of the statutory organisational duty of candour, staff were clear that individuals had a resulting personal responsibility to follow the organisational guidelines and comply with organisational policy. To support this, they reiterated the importance of appropriate training and support in enable them to fulfil their individual duty. There was recognition that the practical application of this would differ according to professional roles and responsibilities, and that there was an important supporting role for professional codes, standards and regulation. There was the expectation that a statutory individual duty of candour would apply to all those working in the HSC, and that staff would need to be supported with training, support and access to expert advice when required.

c. **HSC Staff - What would your concerns be (or potential barriers) if a duty of candour was in place?**

Fear of negative consequences

Staff expressed anxiety about the risk that the introduction of a statutory duty of candour would have negative consequences:

- For individual staff members, the concerns were associated with what might happen to them if a mistake is made, and they were then open and candid about their potential role, **therefore it was as much about the organisational response when things go wrong, as about exercising candour**. In this context there was concern about the impact on job security, increasing the possibility of being personally blamed or scapegoated for an incident. Equally there was anxiety about potential damage to professional and personal reputation, and fear of the threat of losing professional registration and other legal consequences.
- For organisations, the concerns were around **loss of public confidence in the health service and increasing costs due to litigation**. There were also concerns expressed about increasing pressure on staff and that the organisation would become more risk averse.
- For service users, there were concerns expressed by staff that trust might be affected, and that **service users might be negatively affected if information is shared inappropriately**.

Cultural Consequences

Staff expressed concerns about the potential negative cultural impact of the introduction of a duty of candour, **where it has the potential to produce a more rigid, defensive blame culture in which staff are mistrustful of each other and the organisation.** Were this the case, then the consequence would be the practice of more **defensive medicine, the loss of innovation and the health service**

would become an unattractive place to work for new recruits. The responses to this question, as with others like it, provoked anxiety about how errors or mistakes were dealt with, and the duty of candour was seen as an additional factor in exposing staff when a mistake had been made.

d. What can be done to overcome the barriers?

The importance of clear guidance and communication.

Staff identified the need for clear guidance and support to facilitate them exercising the duty of candour. **There was an emphasis on the need for regional guidance and training for staff on how to exercise candour and ongoing support through any investigative process.** The importance of having clear regional guidance, training and support in place was emphasised, but alongside this staff identified the need for access to specialised ongoing support in the context of an investigation e.g. specialist legal advice and specialist clinical advice. **Communicating expectations clearly to staff was seen as critical to the effective implementation of a duty of candour, as was the important role of leadership and management**. Clear and effective communication to staff, service users and the public was seen as critical to ensure that everyone knew what was expected of them and what to expect of others. In a context where these expectations are clear and explicit, staff would feel more confident in challenging others, particularly across teams or up the management structure.

The importance of support for staff

In order to properly exercise the duty of candour staff reiterated the importance of both personal and professional support, for themselves, but also for service users and carers. The general support identified was described in terms of training and supervision to create an environment **where open and candid conversations could become the norm between professionals, with managers and with service users/carers**. In the specific situation where there was an ongoing investigation into an incident, staff identified the need for additional specialised support that included emotional support for the psychological impact that such an investigation might have.

Attitudes towards the introduction of criminal sanctions.

Staff expressed the expectation that where someone had intentionally and maliciously covered up information, provided intentionally misleading information or had lied or withheld information – sanctions were appropriate. Nevertheless, anxiety was expressed that the introduction of criminal sanctions would have negative consequences. **The introduction of the criminal component was seen as potentially destructive**, and out of line with the rest of the UK. The link was made with the processes associated with litigation, and the **possibility of no blame compensation was cited as a positive step towards reducing the possibility of individual blame and scapegoating**. The critical component in this was the issue of malicious intent, and while there was no disagreement that this was unacceptable. However, the introduction of criminal sanctions was seen as possibly having a more negative than positive impact.

e. HSC staff CASE STUDIES: Would it ever be appropriate to apply criminal sanctions if the duty of candour was breached in this scenario? If so, in what situation?

Rationale provided for applying a criminal sanction.

The key rationale given by staff to justify the application of a criminal sanction was **persistent, malicious intent to hide or distort information.** There was recognition that there were possibly different levels of severity, and that criminal sanctions should also be graded to reflect severity. The importance of competent and thorough investigation was highlighted, as was the importance of the organisational responsibility over the individual. Circumstances where organisations had failed to investigate properly, had failed to learn from previous mistakes or had failed to follow their own procedures were also cited as reasons for criminal sanction.

Rationale provided for not applying a criminal sanction.

The rationale for not applying a criminal sanction was linked by staff to the rationale for applying one, namely **if there was no malicious intent**, if it was not persistent and if there was a transparent, professional/clinical reason cited to withhold information, then no criminal sanction should apply. There was some who expressed the view that professional and registrant sanctions were adequate, and there were some who raised questions about the link between criminal sanctions and professional negligence. From the perspective of the principle of introducing criminal sanctions, beyond the examples provided in the case studies, there were those who saw it as being **counter-productive to more openness, candour and transparency**, that it would have a negative impact on culture with the HSC and that it would make the standards in NI more extreme than the rest of the UK.

f. HSC staff - What is the one "big idea" for how we can keep you and others involved in taking this work forward?

Maintaining ongoing communication and updates

Staff expressed an interest in being kept informed on the progress of implementation and provided examples of how best to do this, they included: using trust bulletins, intranets and websites, further local interactive sessions with staff, the appointment of candour champions to support the implementation, explore what candour means using live case studies, and the encouragement of leadership within the trusts to speak about candour and what it will mean.

There was also mention of the importance of listening to staff through the implementation process to ensure that their views were informing it. The **scope of consultation** was also important, with suggestions about student involvement, the involvement of professional bodies and trade unions, as well as an emphasis on the importance of the service user voice throughout the process.

6.3 Third sector views on Duty of Candour

The summary and analysis for the third sector events was provided by Northern Ireland Council for Voluntary Action (NICVA) who hosted the two events. Detailed feedback is included in Appendix 1.3

a. The benefits of introducing a duty of candour

Attendees thought the introduction of a duty of candour would **challenge a culture of blame** and would give individuals and organisations delivering care **clear guidelines and governance,** with clarity of responsibility and process. For the client and service user in particular, attendees said a duty of candour would build more trust and regard in the system.

Some also thought a duty of candour would enable **behaviour change**, instilling better practices throughout the system.

b. The disbenefits of introducing a duty of candour

Attendees thought a major disbenefit of introducing a duty of candour was the potential of putting **additional pressure** on an already under-resourced system. Unintended consequences could be **prolonged delays, additional bureaucracy and higher rates of staff turnover**.

Some attendees thought that, rather than removing the culture of fear, a duty of candour could instil **another level of fear** for an employee, particularly for staff in the social care sector where times are tight for home visits and **peripatetic and lone workers**. Others thought there was potential for **stress on clients**, service users and families, particularly if, for example, under a duty of candour an organisation had to disclose it was experiencing staffing difficulties such as being short-staffed.

Some attendees argued that, if Northern Ireland were to be the **first jurisdiction** to implement a duty of candour, an **unintended consequence** might be test cases and subsequent case law. Attendees thought this could weaken a duty of candour. In addition, attendees thought in some cases a duty of candour could be overly **complex, too rigid** and inflexible. Are the challenges too complex to overcome?

The **role of volunteers** was also considered under a duty of candour – how would that be governed? Attendees also thought more clarity was needed on the ownership of a duty of candour and the remit for regulation of the voluntary and community sector.

At the second event, attendees highlighted the risk of creating feelings of fear, over-monitoring, and suspicion, as well as oversharing inappropriate information. It was suggested that thresholds be set to avoid the latter. They also highlighted the potential risk of creating a **blame culture** (especially in the media); of placing blame on individuals in cases of systemic cover ups; and the risk that the professional judgement of healthcare professionals could be compromised and a culture of playing too safe or becoming too risk averse created, for fear of having to account openly in borderline cases.

The importance of **clarity and understanding around the term** 'duty of candour' was stressed, and concerns raised about whether staff, patients or the public understand what is meant by it. There is

also a need to ensure that a clear distinction is made between making genuine mistakes versus bad practice/systemic failure.

c. What are challenges to introducing a duty of candour?

The greatest challenge to introducing a duty of candour, according to most attendees, was the (**lack of) current resources,** particularly in human resources. Other attendees cited the Department of Health itself as a challenge, particularly referring to a **perceived lack of support for the wider system** and staff. **Geographical challenges** and differing processes for each HSC Trust was also seen as a major challenge to introducing a duty of candour.

Communication and engagement were also seen as a challenge. Attendees asked how a proposed **duty of candour would be communicated** to clients/service users? Attendees also asked how other inspectorates, such as in the Prison Service would be engaged with, along with other Departments and arm's length bodies. Engaging with the **legal profession** was also seen as a challenge.

Media pressure was cited as a challenge, as well as the current lack of Assembly and Executive and no obvious vehicle to deliver the legislative change required to enable the creation of a duty of candour.

At the second event, attendees felt introducing a duty of candour would require training, support and supervision to create a candid culture; adequate resourcing of the administration involved; local policies and procedures; support; and a culture of acknowledging mistakes and reflective practice.

d. How might the challenges be overcome?

The most common suggestion from attendees was providing **adequate training, support and guidance** alongside a statutory duty of candour, as well as a code of practice. This, they argued, would provide for proper implementation and success. Attendees also thought that staff needed to know they are supported to be open and **honest and total protection** for whistle-blowers was required.

Attendees also believed in **greater use of technology** to share information. Currently, it was said, there was no information standard and access to information to, for example, those with hearing implications and visual impairment and attendees believe this should improve.

Attendees also recommended **greater resources to voluntary and community sector** providers in order to maintain the standards required with a duty of candour in implementation.

To iron out issues surrounding **test cases** and subsequent case law, some attendees recommended implementing the duty of candour firstly as a pilot or a trial run.

Other recommendations included **creating a space for shared learning** and conversations with staff, anti-fraud processes (i.e. checking notes and minutes for subsequent amendments) an independently run and well-funded public awareness campaign, and learning from other jurisdictions, particularly exploring the idea of establishing something similar to the Healthcare.

At the 2nd event, attendees stressed the need for **guidance and support** to implement the duty, tailored to different organisations of different types and sizes, and for training across all sectors and specialisms. There should be clear lines of responsibility and sharing of risk.

They felt it was important to create the right culture and avoid a fear of blame and that there was a need to educate the public on the duty of candour. They also stressed the importance of involving patients or their advocates in their own care plans and helping them to make informed decisions without the healthcare professionals abdicating their responsibilities. Consideration also needed to be given to the role of multi-disciplinary teams in making education assessments and decisions, and information-sharing.

Other specific proposals for how to overcome the challenges and barriers to the introduction of a duty of candour included:

- Building in a duty of candour to the values of organisations.
- Having a single duty of candour policy across Trusts, statutory agencies, third sector organisations and all those delivering HSC services.
- Providing modules on duty of candour for healthcare professionals during training.
- Having a duty of candour statement/requirement in contracts agreed by Trusts with third sector and private organisations.
- Putting in place a system that enables the sharing of correct and appropriate information across the whole healthcare sector (trusts, third sector, private) and having clear thresholds for the level of information required.
- Consistent policy-sharing between Trusts and third sector providers.

e. Would criminal sanctions be appropriate in the case of a breach of the duty of candour

At the second event, participants were asked if criminal sanctions would be appropriate. Some respondents felt that as long as an organisation supports you and creates the environment to be open, then if you fail to comply, criminal accountability would be appropriate. Others felt that because criminal liability is quite a severe sanction, there may be more co-operation and compliance if there were instead a civil liability sanction.

Others pointed out that criminal sanctions may let healthcare staff 'off the hook' until an investigation is complete, leading to a continuation of unsafe practice until an investigation is complete, potentially for a significant amount of time.

6.4 Independent Health and Social Care views on Duty of Candour

Under a statutory duty of candour, who would you expect to be told and why or why not?

Considering the case studies, independent Health and Social Care sector attendees identified the following:

1. **Health and Social Care Provider** – assigned staff, Managers, safeguarding champion and Board members.
2. **Health Service Professionals** – commissioners of services, nurse and multi-disciplinary teams.
3. **Patient** – reference was made to capacity of the patient and nominated person or next of kin.
4. **External bodies** – Regulator and PSNI.

a. Consider the different levels for a duty of candour and discuss why or why not it would apply: - Organisational level; - Individual level; - both?

Participants in attendance considered the case studies and identified that the duty would apply to both organisation and individual level. Participants also identified that a clear procedure would be required for the investigation and for the organisation to be candid with the Regulation and Quality Improvement Authority (RQIA).

b. What would your concerns be/or potential barriers if a duty of candour were in place?

Participants in attendance referred to a **blame culture** as a barrier. **Fears** were identified including litigation, not getting all the right information and the impact on individual careers.

Commissioning was a key barrier in relation to the decision-making process and blurred lines with delivery organisations with reference being made to a paternalistic approach. The **imbalance of power** and **over regulation** or different expectations from the regulator were cited. There was reference to an exposure of the independent sector and the consequence of this on their funding.

c. What can be done to overcome the barriers?

Clear policies and guidelines were identified as ways to overcome the barriers with better communication. Sharing examples of candour working well in practice and empowering the independent sector to report concerns about statutory care. The development of **partnerships** between organisations to agree expectations, strengthen communication and consistent involvement of the independent sector. Training was also identified in relation to induction training and how to speak to families and also clarity in relation to completing forms. The use of technology to reduce human error was also identified as a way to overcome barriers.

d. Would it ever be appropriate to apply criminal sanctions in this scenario? If so, in what situation?

In response to the case studies, participants indicated that honest mistakes should not be punished. If there is evidence of hiding, cover-up and also a wilful breach then it may be considered.

e. Independent Health and Social Care sector - What is the one "big idea" for how we can keep you and others involved in taking this work forward?

Communication

Participants in attendance identified that regular feedback and up-dates are required to continue to share information and to highlight further opportunities to be involved. This needs to be for both the Business Owners and staff working in the sector. The importance of listening to the sector was also highlighted.

6.5 Private Healthcare providers views on Duty of Candour

a. Under a statutory duty of candour, who would you expect to be told and why not?

Feedback suggested that the duty would have to include clear requirements about who should be informed dependent on the level of harm caused. The following individuals and organisations were named:

- External referral professional regulators, following investigation establish context.
- Patients.
- Report to organisation's incident system medical director.
- RQIA.

b. Consider the different levels for a duty of candour and discuss in your group why or why not it would apply: - Organisational level; - Individual level; - both?

In the context of the case study considered by the group, it was felt that both duties would apply, and that the individual statements taken would inform the organisational response.

It was also suggested that the individual duty would be easier to implement and the organisational requirements harder to achieve.

c. What would your concerns be/or potential barriers if a duty of candour were in place?

Attendees suggested that the introduction of the duty could lead to apportioning of **blame** to individuals, in order to **limit reputational damage** for organisations. As a consequence, it was felt that **trust** between staff and organisations could be compromised.

d. What can be done to overcome the barriers?

Responses to this question indicated that **engagement** with patients and the provision of **feedback** from incidents. Other initiatives identified that could help overcome the barriers included:

- Interpreters.
- Whistleblowing process.
- PROTECT.
- Legal support.

e. Would it ever be appropriate to apply criminal sanctions in this scenario? If so, in what situation?

Feedback suggested that **covering up information** was a serious issue, and that **patients deserve to know information relating to their care**. Attendees said that **criminal sanctions could potentially be appropriate where information was withheld, there was no reporting or openness with the patient.** However, the use of criminal sanctions would depend on the extent of the **harm** caused to the patient.

f. Private Healthcare Providers – What is the one "big idea" for how we can keep you and others involved in taking this work forward?

Participants in attendance welcomed regular feedback. It was also highlighted that there is a need to identify the separate issues between the sectors i.e. independent sector v nursing / residential sector.

6.6 Service user and carer views on Duty of Candour

In their workshop, the service users and carers supplied the following feedback in respect of when things go wrong.

a. What would you expect to happen?

Feedback clearly indicated that attendees expected organisations to **acknowledge** and **apologise** when something goes wrong at the outset. Attendees also emphasised the importance of **communicating** with patients, carers and families in these circumstances, from the outset and throughout. Feedback also strongly enforced the need to **involve** patients, carers and families in **investigations** when things go wrong, and to share whatever **learning** is identified.

b. What information should be provided?

Responses to this question suggested that any available information should be provided in an **accessible** manner to the patients, carer and family. This may be in a written format with someone available to answer any questions in person if necessary. Once again, feedback clearly reinforced the need for continuous **involvement** of patients, carers and families from the outset in order to ensure that the approach is patient-centred.

c. When should it be provided?

Feedback recognised the importance of **context** in response to this question, but strongly suggested that the available information should be provided to the patients, carers and families as soon as possible. It was recognised that **good record keeping** would be important as part of this process and that **time** would need to be afforded to the patient for reflection, in order for them to contribute effectively.

d. Who should be providing it?

Feedback to this question strongly suggested that a senior member of staff should provide information when things go wrong, with the most frequent suggestion being someone at **Consultant** level. Once again, the need to **support** and **involve** patients when information is being provided was emphasised. The importance of implementing **learning** for the organisation was also seen as a key factor.

e. What support or assistance would you need?

The responses to this question reinforced much of the feedback to this section, with the key forms of support and assistance identified being:

- Independent advocacy.
- The provision of accessible information.
- Clear consistent communication, including opportunities to provide feedback.
- Support for families and carers, as well as staff, to aid understanding.
- Time.

Service users and carers views on criminal sanctions

In their workshop, the service users and carers supplied the following feedback in respect of criminal sanctions and were asked to consider a range of scenarios, as follows:

1. A member of staff forgot to record and share information in relation to a patient's treatment plan.
2. A clinician carries out a consultation. Due to an IT system error, not all information is available as the patient notes have gone missing.
3. A clinician carries out a clinical procedure. An error occurs which causes minor harm. The clinician tells the patient not to worry and that no further treatment is required.
4. A GP receptionist forgets to issue an appointment letter and after the mistake is identified, the patient is contacted immediately.
5. A patient has complications arising from surgery. This is caused by surgical error and the surgeon responsible amends the notes to conceal this fact.

Attendees were asked to identify which of the following consequences would be appropriate:

a) No action.
b) Training required to learn.
c) Disciplinary action through organisation or professional body.
d) Criminal prosecution.
e) Other?

a. The feedback demonstrated that the consequence was dependent upon the scenario in question, and so the majority of respondents felt that the appropriate consequence in most cases would be training or disciplinary action.

b. Criminal prosecution was only considered to be appropriate in respect of scenario 5, where deliberate action had been undertaken to hide an error. However, it should also be recognised that in this case some respondents felt that disciplinary action would be the appropriate level of response.

Service user and carers – What is the one "big idea" for how we can keep you and others involved in taking this work forward?

Participants in attendance identified using different channels to raise awareness and communicate this work with the public including utilising social media and via primary care services such as GP or Dental practices.

6.7 Dental sector views on Duty of Candour

a. Under a statutory duty of candour, who would you expect to be told and why or why not?

Feedback suggested that the duty would have to include clear requirements about who should be informed dependent on the level of harm caused. The following individuals and organisations were named:

- **Health service professionals –** Dentist, GP and Nurses.
- **Dental practice staff –** Practice owner or manager and team for learning.

b. Consider the different levels for a duty of candour and discuss in your group why or why not it would apply: - Organisational level; - Individual level; - both?

In the context of the case studies considered by the group, it was felt that both duties would apply. In relation to applying an organisational duty, it would have to be flexible to take into consideration the business model for dental practices.

c. What would you concerns be/or potential barriers if a duty of candour were in place?

Participants strongly identified a **blame culture rather than a learning culture**. The fear of self-incrimination and litigation prevents candour. Professional damage was referred to in the context of cost/profit implications. The need for **indemnity advice** was required.

Regulation was also raised in relation to frequency and **over-regulation** and finding a method to show individual practices are being candid.

d. What can be done to overcome the barriers?

Respondents identified **appropriate regulation** and GDC recognition of early application of candour. The culture and the need to build effective relationships with patients with suggestions including

introducing a 'no blame' culture, changing the litigious culture and no criminal sanctions were also identified.

The challenge of the **dental practice as a business** was identified with the need to support the public on what is candour and also having support from other organisations.

e. Would it ever be appropriate to apply criminal sanctions in this scenario?

Based on the case studies, the responses identified no as the cases were short of the threshold and professional regulation being appropriate. A difference of opinions in some circumstances occurred with some feeling that covering up might be a criminal offence whilst others thought not.

f. Dental sector – What is the one "big idea" for how we can keep you and others involved in taking this work forward?

Ongoing communication and updates

Participants expressed an interest in being kept informed and involved in progressing the implementation and examples of how best to do this included further workshops, online surveys, social media, emails, HSCB dental newsletter, on-line resource etc. Clear messages and short up-dates with the opportunity to feedback was asked for.

All members of the dental profession needed to be included such as practice managers and dental nurses and the opportunity to gain CPD points was a good incentive to support involvement. A call was also made for sessions to take place across Northern Ireland.

The sector also highlighted the importance of their role in the change/transformation agenda to communicate and educate the public.

6.8 Social Care Managers views on Duty of Candour

As part of the engagement with Social Care Managers, Northern Ireland Social Care Council (NISCC) facilitated the inclusion of a duty of candour workshop as part of a Social Care Managers Forum and also an Extension for Community Healthcare Outcomes (ECHO) Project meeting which also engaged Social Care Managers.

In the workshop at the Social Care Managers Forum hosted by NISCC, Social Care Managers supplied the following feedback in respect of the duty of candour.

a. What is the most important element of this for you?

A range of responses were provided to this question, predominantly linked to theme of everyone working together to build trust and create a culture of openness. It was clear that transparency and openness were important values for those delivering social care, and that it would be important to

remove any fears staff might have about being open by providing adequate support, such as training programmes. Attendees also felt that by promoting openness and sharing learning to improve patient safety, organisations would be better able to learn from mistakes.

b. How should we engage and involve the social care workforce?

Feedback to this question predominantly suggested a preference for face to face involvement through workshops or roadshows. Similar approaches were also suggested, such as team meetings training sessions and the NISCC Registration Process, and the importance of good communication using accessible information was emphasised throughout. There were also a number of alternative approaches suggested, including e-learning platforms.

Throughout the feedback received, it was apparent that support for staff to be open was a key concern for those involved.

At the workshop hosted by the ECHO Project, Social Care Managers supplied the following feedback in respect of being open and the duty of candour:

a. What would your concerns be if a potential duty of candour were in place?

Feedback on this issue identified **fear** amongst staff as a potential negative consequence of introducing a duty of candour. This fear would be influenced by a blame culture, lack of leadership or support for staff, protecting against reputational risk, and the impact of increased regulation. Once again, the importance of resources to support an open culture was noted.

b. What can be done to overcome these concerns/barriers?

Feedback emphasised the need for support to successfully implement a duty of candour. This included support for individual staff, supportive regulation, support from line management and structures to support implementation. The importance of a just culture, where it is recognised that mistakes happen and openness is promoted as key value to improve learning, was also identified.

e. Would it ever be appropriate to apply criminal sanctions?

Feedback on this particular issue was limited although it was noted that a lack of honesty could be punished by a fine or disciplinary procedures.

f. Social Care Managers – What is the one "big idea" for how we can keep you and others involved in taking this work forward?

Participants called for regular up-dates and the need for guidance to be co-produced with the sector.

6.9 Pharmacy Leads views on Duty of Candour

a. Would it ever be appropriate to apply criminal sanctions for a lack of openness or candour? If so, in what situation?

Feedback suggested that professional sanctions achieve the same aim and are proportionate. There was also some questions about how the organisational duty would operate. Attendees felt that a criminal sanction for a lack of candour should not be used to punish mistakes.

b. Pharmacy sector – What is the one "big idea" for how we can keep you and others involved in taking this work forward?

Participants discussed how best to involve others and identifying a wider event to engage with the sector.

6.10 G.P. Practice views on Duty of Candour

a. Under a statutory Duty of Candour, who would you expect to be told and what level would apply, i.e. organisational and/or individual – tell us why?

- Overall it was felt that the case study was not appropriate in the context of the duty of candour because the majority of respondents felt that the clinical approach taken was reasonable, and that not disclosure or openness with the patient was required.
- However, some respondents identified the potential for learning, and the need to communicate openly with a patient if any errors in care are identified.
- The importance of shared-decision making and communicating risk with patients when recommending a course of treatment was emphasised.
- The key consideration was the level of harm that the patient came too, and it was apparent that the threshold would be a key consideration when considering a statutory duty of candour.
- Concern was expressed about a statutory duty of candour leading to defensive medicine, and unnecessary referrals to other services because of a safety-first approach.
- The importance, and potentially time-consuming nature, of record-keeping was highlighted.

b. What would your concerns be if a statutory Duty of Candour was in place?

- Cost, including indemnity and insurance.
- Time, including the additional paperwork involved.
- Defensive medicine/risk averse practice, including the potential impact this may have on the wider health service.
- Fear of litigation.
- Professional regulation.
- Impact on recruitment and junior staff.

- Damage to morale, including stress.
- Increased complaints.

c. What can be done to overcome these concerns?

- Opposition to the introduction of a statutory duty of candour with criminal sanctions was expressed and concerns were raised to DoH regarding its introduction.
- Feedback advised against a blanket approach, and that any duty should differentiate between different settings.
- Increased time and resources to successfully implement a statutory duty of candour was mentioned frequently.
- The importance of a focus on learning and the absence of a blame culture was expressed by respondents.
- The inclusion of protections against increased litigation was mentioned.

d. Would it ever be appropriate to apply criminal sanctions if the Duty of Candour was breached? If so, in what situation or for what behaviours?

- Some respondents felt that sufficient sanctions already existing, both within the criminal law and as part of professional regulation.
- However, others recognised that if intentional criminal behaviour was committed – deliberately concealing information, destroying information or providing misleading information – then criminal sanctions would be appropriate.
- It was recognised that these behaviours are criminalised in other settings and in statute already.
- The importance of ensuring that the definition of the offence captured only serious criminal behaviour was also highlighted.

6.11 Professional Bodies views on Duty of Candour

Feedback highlighted the following:

- Understanding the fear in relation to staff worries, conflict between organisations and individuals in relation to prosecutions.
- The role of professional regulation.
- The difference between small practices and large organisations – in small practices the individual and organisation can be the same.
- Concern over recruitment and retention of medical professionals.
- Cultural change to change behaviours rather than punishment – the need for a no blame culture and the involvement of the public.
- Need to include social care workers.
- Level at which case law will apply.

6.12 Current statutory responsibilities, professional standards, guidance etc.

All sectors were asked to identify what current statutory responsibilities, professional standards, guidance etc. would you apply? Responses have been categorised below:

a. **Statutory Responsibilities** e.g. legislation, Human Rights, Equality, Capacity & Consent, Guardianship, Gillick competence, Duty of Care etc.
b. **Regulation** e.g. RQIA.
c. **Professional Standards** e.g. SAI, Nursing and Midwifery Council (NMC) RQIA, GDC, Royal Colleges, NISCC, GMC and insurance requirements etc.
d. **Guidance/Protocols** e.g. National Institute for Health and Care Excellence (NICE), GDPR, SAI, Child Protection/Gateway services, Standard Operating Procedures (SOPs), National Health Service (NHS) Guidance in relation to payments, Significant event reporting etc.
e. **HSC/Trust Guidance** e.g. HSC Values.
f. **Individual Trust/Organisational Guidance/Protocols** e.g. referral processes, reporting systems, joint protocols, DATIX reporting, complaints, compliments, whistleblowing etc.
g. **Human Resource Guidelines** e.g. appraisals, employment contracts, disciplinary procedures etc.
h. **Contract agreements** e.g. Business contracts between Trusts and independent providers.