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IHRD Implementation Programme

What does a Duty of Candour mean for Health and Social Care?

INVOLVEMENT EVENTS APPENDICES

(Third edition – Consultation events to November 2020)

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IHRD Programme Workstream 1 – Duty of Candour

Contents

Section 1 APPENDICES SUMMARY of RESPONSES 3

APPENDIX 1.1 Summary Patient and Client Council membership views on Duty of Candour 3

APPENDIX 1.2 Summary HSC staff views on Being Open & Duty of Candour 8

APPENDIX 1.3 Summary of Third Sector views on Duty of Candour & Being Open 25

APPENDIX 1. 4 Summary HSC staff views on Event Organisation 33

APPENDIX 1.5 Summary Independent Health and Social Care sector views on Duty of Candour and Being Open 37

APPENDIX 1.6 Summary Private Healthcare Providers views on Duty of Candour and Being Open ... 42

APPENDIX 1.7 Summary service user and carer views on Duty of Candour and Being Open 46

APPENDIX 1.8 Summary Dental sector views on Duty of Candour and Being Open 58

APPENDIX 1.9 Summary Social Care Managers views on Duty of Candour and Being Open 66

APPENDIX 1.10 Pharmacy Leads views on Duty of Candour and Being Open 72

APPENDIX 1.11 GP views on Duty of Candour and Being Open 76

APPENDIX 1.12 Professional Bodies on Duty of Candour and Being Open 81

Section 2 APPENDICES WORD CLOUDS from Involvement Events 84

APPENDIX 2.1 HSC staff views - What does an open organisation look like for staff? 84

APPENDIX 2.2 HSC staff views - What does and open organisation look like from a patient/carer perspective? 85

APPENDIX 2.3 HSC staff views - What are the barriers to an open culture? 86

APPENDIX 2.4 HSC staff views - How could we overcome the barriers? 87

APPENDIX 2.5 HSC staff views - What statutory responsibilities, Prof standards, guidance etc can assist with the Duty of Candour? 88

APPENDIX 2.6 HSC staff views - Concerns or potential barriers to a Duty of Candour? 89

APPENDIX 2.7 HSC staff views - Ways to overcome barriers to a Duty of Candour 90

APPENDIX 2.8 HSC staff views - Views on criminal sanctions to breaches to a Duty of Candour 91

APPENDIX 2.9 HSC staff views - Big idea to keep people involved 92

APPENDIX 2.10 Third Sector views on Being open and Duty of Candour 93

Section 3 APPENDICES EVENT Supporting information 95

APPENDIX 3.1 Case study examples –Involvement events 95

APPENDIX 3.2 Summary of individuals involved 104

Section 1 APPENDICES SUMMARY of RESPONSES

APPENDIX 1.1 Summary Patient and Client Council membership views on Duty of Candour

IHRD What does a Duty of Candour mean for Health and Social Care?

SUMMARY of FEEDBACK

Patient and Client Council membership events

This was the first in a series of involvement events by the IHRD programme that was designed to test the design and process of involvement and engagement with stakeholders on the issues of a statutory duty of candour[1]. Following the Patient and Client Council (PCC) initial event, the introduction presentation for the subsequent PCC Membership event was adapted to include a focus on being open.

2 events took place in Northern Ireland, attended by 132 participants hosted by the Patient and Client Council:

- Belfast 22 May 2019 (107 attendees)
- L'Derry June 2019 (25 attendees)

The PCC host annual events for their Membership Scheme members. As part of these events, a duty of candour workshop was undertaken to determine a level of awareness and understanding from a public perspective in relation to a Duty of candour. Information gathered from the workshops will assist to lay the groundwork for future involvement activity aimed at service users, carers and the public to ensure moving forward they are meaningfully engaged as part of the programme of work.

Event Format

An **introduction** to the Hyponatraemia Inquiry was given to provide an overview and background to the programme of work. Recommendations relating to a duty of candour and being open were presented in a summarised format and an overview of what this will mean in practice for service users and carers was presented.

At each event, participants were asked a series of 6 questions before breaking into a workshop to discuss a duty of candour. Each table was presented with a case study and participants were facilitated to consider further information in relation to a duty of candour. Participants were also asked what questions we should be asking service users, carers and the public to inform this work. At the end of the

[1] In line with the statutory duty to involve and consult with service users, carers and the public.

workshop discussion, participants were re-asked the 6 questions to determine how their thinking had changed as a result of the table discussions.

The findings from the questions and workshop findings are set out below.

Case scenarios:

Participants worked through 6 case scenarios to address a number of questions in relation to being open and the duty of candour. A summary of responses is set out in the following section.

1.1 PCC Group work questions: DUTY OF CANDOUR

1	From each of the 6 case examples - does a duty of candour apply?

- In 5 out of 6 case examples all groups agreed that the duty of Candour applied
- The exception was in the case where the dental nurse informed the family member of a family death - all agreed that although it should not have happened, and may have been a breach of confidentiality, the duty of candour did not apply as care was not being delivered to the deceased person, the information was in the public domain and that the nurse was being friendly and concerned.
- In 2 other cases the group caveated their response:
  - In the social care example the group agreed that the person making the complaint (in respect of child welfare) about the family should be protected and remain anonymous but that candour applied in respect of the family being aware that a compliant had been made
  - In the case where the family believed the individual did not wish to know of a terminal diagnosis it was agreed that personal circumstances and preferences should be taken into account. There was disagreement on whether the person should be told the diagnosis with most respondents believing they should be told
- Respondents stressed the need for communication, within the clinical teams and with the service user and family
- Some commented that insufficient information given to comment in detail
- Importance of 'no blame' culture and be-briefing for staff when things go wrong
- The value of support for staff and for families, particularly the availability of advocacy to enable questions to be asked later or answers followed up

2	From each of the 6 case examples – does a duty of candour apply in all circumstances?

- Honest communication was stressed and agreement in 4 out 6 case scenarios that the duty of candour did apply

- In the 2 cases with exceptions it was noted that: the information was available elsewhere in the public domain and not a breach of duty in one case;
- In the second case the preferences of the individual needed be taken into account

- Agreement that duty of candour should <u>apply in all circumstances</u> where mistakes are made and things go wrong – which some believed it also applied to 'near misses'

- Comment made in every example about the quality of communication and need for sensitivity in communicating distressing information

- Issues raised about those with dementia, mental ill health or who have a clear stated preference not to be informed in which case others need to be informed on their behalf – no concealment

- Comments made that issues where there are issues of the protection of children or vulnerable adults is already covered by law

3	**What are the obstacles/barriers to being candid and what can be done about it?**

- <u>Fear</u>
  - Litigation and reputational damage (individual and organisational)
  - Staff incriminating themselves and personal repercussions
    - Staff need support and protection
    - Training for openness and candour
  - Harming service users/ families with distressing information
  - Fear of society moving towards a blame and compensation culture

- <u>Poor communication with service users and families</u>
  - Taking time and communicating in a sensitive and compassionate way
  - Careful use of language and jargon
  - Training and supervision for staff – particularly doctors
  - Using GDPR/ data protection inappropriately as rationale for not communicating with carers/ families

- <u>Blame culture</u>
  - Tracking the chain of responsibility
  - Not blaming staff who are under pressure – looking across the team
  - Focus on the learning outcomes

- <u>Specific staff issues</u>
  - Agency staff ('tendering') who don't know the patients or systems
  - Culture of 'doctor is always right' and resistance of older consultants to change

- <u>Service user preferences not to be given information</u>

- Support and advocacy particularly for older people and those with mental health issues
- Awareness raising for service users to understand their rights to information

- Leadership

  - Needs a top down approach to ensure a cultural change

4 What questions should we ask service user, carers and the general public to help inform the work?

The groups made many general comments in response to this question

- Learn from your mistakes
- Accountability needs to be clear
- Public need to be aware that they are entitled to information
- Case studies helpful
- Staff and service users should not be afraid to speak up
- Better training for staff in family dynamics e.g. doctors and social workers
- Cultural and language issues may be barriers

Questions to ask for service users, carers and families to inform the work

- Do you know how to get information?
  - How should awareness be raised?
  - Should be advertised on wards
  - Accessible information on complaints process
  - Patient reference groups in GP Practices and focus groups
  - Print versions of information more accessible for some not just digital
  - Helpline to answer questions on what to expect from candour

- In what circumstances would someone like more or less information? Examples?
  - Should people be asked at the outset what level of information they want?
- Should advocates be involved in some circumstances? Examples?
- Do you support a duty of candour?
- How would you use a duty of candour?

5 Any other comments

- As well as a duty of Candour there should be a duty to learn from mistakes
  - Learning should take place more quickly

- Duty of candour
  - Should be exercised without it having to be asked for
  - Offering an apology should be part of the duty of candour

- A 'no blame culture' essential and staff should be protected
- Advocacy should be built in
- Compensation is not always the answer
- Staff have to 'buy into' the duty of candour or nothing will change
- Consider concept of 'truthfulness' rather than candour

- Clinical staff need to listen to the experience of users and carers not focus on qualifications and need to be clear about whose 'best interests' are being protected

- Communication across individuals and teams and with service users on treatment and care being provided – better pathways for information

6 Turning point results

Respondents were asked to state their views prior to and immediately following the event using Turning Point online feedback technology. The aggregated results from both events is summarised below which show a change in understanding and perception of specific issues in the duty of candour.

a. Understanding of Duty of Candour - YES
Before: 50-67% After: 84-100%

b. Importance of Duty of Candour – VERY
Before: 56-100% After: 74-100%

c. Value of Duty of Candour in creating an open culture – YES
Before: 68-86% After: 86-60%

d. Views on staff candour with all services users every time –YES
Before: 76-83% After: 68-71%

e. Circumstances where not being open in service user's interest – YES
Before: 34-55% After: 62-88%

f. Relevance of Duty of Candour when no mistakes made – YES
Before: 14-11% After: 14-29%

APPENDIX 1.2 Summary HSC staff views on Being Open & Duty of Candour

IHRD What does a Duty of Candour mean for Health and Social Care?

SUMMARY of FEEDBACK

6 events took place throughout Northern Ireland reflecting the Health Service Trust areas

- WHSCT - Waterfoot Hotel 45 attendees
- NHSCT - Dunsilly Arms Hotel 80 attendees
- SEHSCT - The Pavilion 88 attendees
- SHSCT - Craigavon Civic Centre 82 attendees
- WHSCT - South West Acute Hospital 39 attendees
- BHSCT - Grosvenor House 67 attendees

Participants:

401 staff attended events comprising - 148 nursing; 65 admin & clerical; 43 medical/ dental; 16 multi-professional; 31 social services; 25 scientific/ technical; 15 support/ user experience; 8 ambulance; 17 senior executives and the remaining 33 participants unspecified.

Event Format

An **overview** was given of the recommendations of the Hyponatraemia Inquiry relating to duty of candour and being open, and an overview of the process of the Implementation Programme and the co-production model. The introduction ended with recordings of Dr Dermot Hughes, Medical Director, WHSCT and Maria Somerville, Carer, workstream member, speaking of their involvement in the implementation programme, and a film from the SHSCT about how a serious adverse incident was handled from a family's perspective.

The work of the **Being Open workstream** was presented its relationship to a statutory duty of candour. This focused on cultural change within the health service to a more open system and the opportunity to implement these changes quickly compared to the longer timescales associated with the introduction of candour legislation.

At each event staff worked in groups to discuss a number of case scenarios and consider questions in relation to being open. These are summarised below.

1.2 Part A HSC Staff Group work questions and summary of feedback: BEING OPEN

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

- "No Blame Culture"

- Promote a "just culture"
- Corporate vs individual responsibility when mistakes happen
- Fear of repercussions when concerns are raised
- Fear of personal and professional liability
- Fear of litigation
- Fear of reputational damage
- Fear of job loss or sanctions
- Fear of scapegoating individuals
- Governance needs a face
- Focus on system failure rather than blaming individuals
- Differences between professions - different levels of responsibility
- Expectation that mistakes will happen – the new normal
- Positive and open reaction to complaints

- Open Communication

  - Free to speak up with concerns
  - Use appropriate accessible language
  - Good team relationships
  - Good managerial relationships
  - High levels of trust with peers and managers
  - Structured time available to reflect on what has happened and share information
  - Challenging practice is the norm
  - Listening to the voices of service users and staff equally
  - Honest and transparent communication
  - Have an online portal for concern
  - Have open "champions"
  - Even the smallest concerns get a response
  - Quality feedback – time available for genuine listening
  - Structured feedback during a complaint process, even when there is little progress

- Structure and Processes

  - Clear expectations reflected in clear policies and processes
  - Consistent policies and processes across all trusts
  - Single point of management contact for an issue
  - Policies reflect values
  - Regular reflection and organisation wide audit
  - Clear understanding of process and what to expect as the next steps
  - Patient centred processes
  - Coordinated approach to problems across individuals and teams
  - Clear accountability for managing the process
  - More cohesiveness and less boundaries between teams and departments
  - Appropriate staffing levels and openness as part of staff induction
  - Better management of the media relationship

- Supportive management and leadership

  - Collective leadership
  - Management have an open-door policy for staff

- Flat hierarchy and shared responsibilities
- Management open to being challenged themselves
- Management support staff when things go wrong
- Managers are champions of openness
- Managers are open and approachable
- Single point of contact in management for specific issues
- Managers open about making mistakes themselves
- Team responsibility vs individual blame
- Managers clearly aware of the openness policies and practices

- Learning Culture

  - Teams are open to sharing learning
  - Mistakes are seen as learning opportunities
  - There is a structure for learning and reflecting on practice
  - Structured time is made available to reflect on what has gone well and what has not
  - Education and ongoing training and development are actively promoted
  - Training specifically on openness and the policies and practices
  - Staff are supported as well as trained
  - Supervision includes time for reflection and learning from mistakes
  - Reflective practice is encouraged and accommodated
  - Learning is shared at an organisational and regional level

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

- Honest Communication

  - Be told the truth
  - Compassionate communication
  - Kindness to patients and carers
  - Openness about what matters to the patient/carer
  - Patients don't think information is being withheld
  - Answering all questions
  - Perspective is validated
  - Two-way communication
  - A competent person answering the questions
  - Person fit for challenging conversations
  - Plain English / other languages accommodated
  - Open to feedback

- Accessible systems

  - Easy access to the information needed
  - Open access to notes / paperwork
  - Patients not afraid to speak up
  - Families aware of who to speak with
  - Clear explanation of the process
  - Clear explanation of why the HSC person is there / their role

- Timely production of information
- Clear signposting
- Free from jargon
- Language modified to account for patient/carer needs

- Personable

  - Supportive to patient/carers
  - Single point of contact
  - Face to face communication
  - Kind and compassionate approach
  - Respectful and approachable
  - Easy to contact – visible
  - Non-defensive staff
  - Not intimidating
  - Person centred – treated as an individual
  - Consistency
  - Apologetic where appropriate
  - Enough time given for explanation

- Clear processes

  - Pro-active engagement – not waiting to be asked
  - Clear communication of the process
  - Ongoing updates on the process, even if no progress has been made
  - Patient/carer involved in the process at all points
  - Continuous engagement
  - Not just focused on learning but on the patient/carer needs
  - Early engagement
  - Appropriately qualified professionals involved at each stage who are qualified to answer questions
  - Information/learning shared within and between trusts
  - Process allows time for involvement
  - Support throughout the process – patient advocate?
  - Managing expectations

3. What are the obstacles/barriers to being open?

- Fear

  - Negative consequences: litigation/ criminal investigation /disciplinary action/ sanction from professional bodies
  - Getting it wrong: making an inappropriate response/ of being wrong – professional pride/ making a bad situation worse
  - Organisational: letting colleagues and department down/ reputational damage/ general media response – e.g. Nolan
  - Personal: being verbally or physically attacked/ social media abuse/ being scapegoated/ losing job/ stigma and shame
  - Previous experiences: negative experience of openness/ worse could happen if you complain

- Capacity

  - Time pressures – no time to respond
  - No time capacity to be involved in investigations
  - No administrative support
  - Lack of resources
  - People are institutionalised
  - Lack of training for staff
  - FOIs are a barrier now

- Confidentiality

  - Openness can conflict with confidentiality
  - Principle of consent causes difficulties with openness

- Management/leadership

  - Lack of follow-through from managers
  - Bullying
  - Lack of support
  - Protecting professions
  - Response dependent on attitude of manager
  - Hierarchy - Junior staff not open because of fear
  - Operationally, staff far removed from senior managers – need more visibility
  - Poor leadership
  - Need regular good quality supervision
  - Need support from management
  - Paternalistic culture – junior inexperienced staff
  - Issue of trust across professional relationships
  - Lack of protection/support for staff

- Processes

  - Culture of reliance on doctor authorisation before releasing information
  - Need clear pathway to be open
  - Systems – both IT and administrative don't facilitate openness
  - Inappropriate escalation rather than local resolution
  - Fear that apology is seen as an admission of guilt
  - Legal process is a barrier to openness
  - Media policy is "not to respond"
  - Inconsistent reporting policies across trusts
  - Adversarial nature of clinical negligence process
  - Lack of streamlined processes

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

- Processes

  - Clear guidelines on openness
  - Clear policies and procedures
  - Begins at induction
  - Support for a person making a complaint
  - Process maps
  - Structured systems for families to contact staff
  - Easy reporting systems
  - Separate and distinguish learning from legal processes
  - Less time consuming systems
  - Review the complaints process
  - Feedback from DATIX and SAIS needs to get to the right people
  - Clear involvement of patients/carers in the processes
  - Making best use of advocates in the community
  - Independent SAI team for all trusts
  - Link policies and guidelines to core trust values of honesty and openness
  - Create culture of early learning rather than leaving it too late
  - Feedback should include positive affirmation
  - Protected time for staff to follow procedure
  - Removal of criminal sanctions – criminal element could be a barrier
  - Ensure legal advice allows organisation to be open
  - Resource governance support
  - Reform of clinical negligence
  - Central point of contact for process
  - One policy covers all – including communication across trust
  - Public facing forum to give out the difficult messages

- Training and Supervision

  - Training in openness for all staff
  - Should start at induction
  - Learn from the past – Donaldson Report/ Berwick Report
  - Allow time for professional development
  - Undergraduate training
  - Value clinical supervision
  - Include openness in annual appraisals
  - Share learning across trusts
  - Training to have open conversations
  - Training in interpersonal skills
  - Training to have difficult conversations
  - Learning lunches – to learn not to blame
  - Meaningful supervision – for learning not a tick-box
  - Coaching for staff

- Ensure training is in multidisciplinary sessions

- Leadership and management

  - Need good role models
  - Leaders and managers need also to celebrate successes
  - An open door policy
  - Visible leadership out on the floor
  - Monthly meetings to focus on key areas
  - Balance and getting support when being verbally abused for the protection of staff
  - Review of roles and portfolios at a higher level to provide more time
  - Recognising challenges of unwell staff – MH issues
  - Have a "freedom to speak up" guardian

- Patient /Carer involvement

  - Involve people from the beginning and at all levels
  - Voices for children – 16+
  - Management of patient expectations
  - Open conversations with families from the beginning
  - Allowing family a single point of contact
  - Language and communicating – check understanding
  - Learning from lived experience
  - Use of expert patients
  - Personal engagement of staff with public on a 1-1 basis
  - Making best use of advocates in the community
  - Encourage service users to give feedback even if they don't want to make a complaint
  - Co-production
  - Service users supporting other service users
  - Use the service user input to change services
  - Real-time feedback for patients/carers
  - Communicate shortages to the public so that they understand the struggles
  - More uniform approach to the information the public get

APPENDIX 1. 2 PART B Summary HSC staff views on Duty of Candour

IHRD What does a Being Open mean for Health and Social Care?

SUMMARY of FEEDBACK

Introduction

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An overview of the recommendations was presented relating to the introduction of a **statutory individual and organisational duty of candour**, with consequent criminal sanctions. Discussion of the workstream's process, the work done so far and contextualising the introduction in the light of existing professional regulation. There was then the opportunity for the groups to discuss duty of candour using case studies (see appendix) and guided questions.

At each event staff worked in groups to discuss a number of case scenarios and consider questions in relation to the duty of candour; these are summarised below.

1.3 Part 2 HSC Staff Group work questions and summary of feedback: DUTY OF CANDOUR

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

This question provoked different answers depending on which case study the group was considering. The general principles coming from the groups were:

- Who should be told - Wide range of people directly related to the patient may be told as well as the patient themselves, this raised issues of consent, capacity, power of attorney and the right of the patient to determine who and who not should be told:
  - Immediate family
  - Next of kin
  - Carers

- Health service professionals - The issues of who within and outside the team directly dealing with the patient should be informed. This included escalation through the chains of management and clinical responsibility, as well as consultation with DOH, primary care, pharmacy, theatre staff, lab and other related health professionals.

- External bodies - The issues of who, outside of health and social care should be informed and when. This included:
  - Professional bodies e.g. GMC, NMC, RQIA, PHA, Medical Defence etc.
  - PSNI in the context of invoking the joint protocol
  - Safeguarding
  - Guardian ad litem service
  - Coroner

- The appropriate processes to follow. This covered the issues around the processes for recording what has happened, through these who is then necessarily informed and the mechanisms for invoking these processes.
  - Initiating an SAI
  - Datix
  - Discussion at mortality and morbidity meeting
  - Complete IR1
  - Consult legal team
  - Determination of potential criminality

- Principles of consultation:

  - Importance of clarity about who can give consent and to whom
  - Importance of clarity about capacity

- Importance of clarity about who has a right to be told, and who can be told
- Importance of clarity about the chain of responsibility and who is responsible at each stage
- Importance of capturing the learning from the incident
- Relationship between confidentiality and candour
- The issue of children and consent
- Openness as a norm – better to be candid up front
- Long term candour at the outset would be better
- Whether information should be volunteered, or wait until asked

2 CASE STUDIES: Consider the different levels for a duty of candour and discuss why or not it would apply to the following?

- Statutory **Organisational** Duty of Candour

  - Responsibility to coordinate a response to an issue
  - Responsibility to bring in other services – legal, PSNI
  - Responsibility to raise awareness of duties
  - Responsibility for education training and awareness
  - Responsibility for consistent implementation of policies and procedures
  - Responsibility to provide clear guidance
  - Importance of good governance and management
  - Clarity of the organisation legal position and how this is exercised
  - Responsibility is organisational not individual if there is a systemic problem

- Statutory **Individual** Duty of Candour

  - Individuals have a responsibility to follow processes, procedures and guidelines
  - Importance of individual training and awareness
  - Issue of individual's capability
  - Role of professional codes, standards and specialist responsibilities
  - Practical application of a duty of candour is at an individual level
  - The importance of access to legal advice
  - Should apply to all HSC staff
  - Staff should be supported by their organisation
  - Should be easier to report

- Criminal sanctions where the duty of candour has not been followed

  - Possible criminal sanctions for the person who suggested covering up the mistake
  - Possible criminal sanctions for person deliberately withholding information

3	What current statutory responsibilities, Professional Standards, guidance etc. would you apply?

- Statutory responsibilities:
  - Mental Health act/ Mental Capacity Act/ Capacity legislation:
  - Capacity and consent
  - Guardianship
  - Human Rights Act
  - Equality legislation
  - Children's Order
  - Duty of Care
  - Duty to involve the public and consult
  - Duty of quality
  - Legal duty/criminal legislation
  - Health and Safety Order

- Regulation:
  - RQIA

- Professional Standards/Regulators:
  - RPS/ Pharmaceutical regulations
  - GMC
  - NMC
  - NISCC
  - GDC
  - GP's
  - Royal colleges
  - Health and care professional council
  - Lab regulations

- Guidance/protocols/policy:
  - NICE Guidelines
  - Good Medical Practice
  - GDPR/Data protection/Data sharing procedures
  - Confidentiality
  - SAI/ incident reporting/ near miss/ Never events
  - Child protection/Gateway services
  - Safeguarding
  - Whistleblowing
  - Patient Client Experience Standards
  - Risk Assessment
  - Being Open
  - Green book
  - WHO checklist
  - Standard Operating Procedures (SOPs)
  - Cancer Registry

- Complaints
- Breaking Bad News
- Morbidity and Mortality Guidelines
- Audit
- Medical Defence Union
- Good Relations
- Notifiable disease – check
- Social policy
- Public Health

- HSC/Trust guidance:
  - HSC Values

- Individual Trust guidance and protocols:
  - Referral processes
  - Trust Values
  - Reporting systems
  - Joint protocols
  - Code of Ethics
  - Theatre checklist
  - DATIX reporting
  - Legal
  - Escalation policies
  - Governance and procedures
  - Communication
  - Mandatory training

- HR:
  - Job description
  - Appraisal
  - Contract of employment/Code of conduct
  - Disciplinary

4	**What would your concerns be (or potential barriers) if a duty of candour was in place?**

- Fear
  - Being disciplined
  - Reputational damage
  - Being judged
  - Being individually blamed/scapegoated
  - Individual blame versus organisational responsibility
  - Losing professional registration
  - Sharing information inappropriately
  - Exposing the trust and losing public confidence

- Loss of business/consequences could close the organisation
- Financial loss to the organisation
- Judgement of the patient
- Legal/criminal consequences
- Pressure from management
- Causing distress/concern to patients/carers
- Increasing stress levels of staff
- Making the organisation more risk averse
- Negative impact on patient's family/carers
- Risk employment
- Not being supported by trust
- Litigation
- Breakdown of trust with patients
- Media coverage
- Personal mental health impact

- Cultural consequences

  - Defensive medicine
  - Blame culture
  - Negative impact on staff recruitment and retention
  - Duty of candour working against a culture of openness
  - Possibility of introducing a DOC and people not following it
  - Seen as a stick not a carrot
  - Could form a culture of mistrust – between colleagues and between the public and the service
  - Will focus attention on bad practice rather than good practice
  - A rigid legislative framework would detract from good personal care – staff will become less caring
  - Will stifle innovation
  - People will not want to come to work here
  - Promotes attitude of "we'll tell you and to hell with the consequences"
  - Turns everything legal
  - Potential conflict between DOC and clinical risk assessment
  - Importance of clear guidelines, policy and procedures

- Process Issues

  - No discussion about whether DOC is the right way to go
  - Are we assuming that the public want a DOC

5 What can be done to overcome the barriers?

- Communication

  - Clear advice on what can and cannot be said
  - Clear policies and procedures
  - Honest communication
  - Clear legal advice
  - Clear clinical advice
  - Clear procedures for escalation of communication
  - Induction and other training
  - Improve awareness of DOC
  - Making it clear how to make a complaint
  - Consistency across all staff
  - Make it normal that patients can access information
  - Having anonymous processes to raise issues
  - Importance of clear leadership on candour
  - Opportunity for staff to reflect on learning from mistakes
  - Being able to challenge management and other professionals
  - Regional consistency of communication and guidance
  - Leaflets for families on DOC
  - Importance of clarity across teams
  - Ensure public awareness of when DOC is introduced
  - Reflect sectoral differences
  - Minimise bureaucracy
  - DOC should be explicit in staff employment contracts

- Support

  - Support the patient and communicate effectively
  - Supervision for staff
  - Changing culture and empowering staff
  - Emotional support
  - Being empowered to be open
  - Specific support for staff after an adverse event
  - DOC can support staff where an organisation is trying to hide information
  - Have collective responsibility for mistakes
  - Protection and compassion for staff while acknowledging and investigating what has gone wrong
  - Ensure staff have enough resources to do their job
  - Need for independent investigations
  - Need support to implement DOC

- Sanctions

  - Sanctions for people covering up intentionally
  - Don't attach a criminal sanction – none of us enter the health service to cause harm
  - Implement the DOC, but the criminal sanction is a barrier
  - Remove the possibility of a criminal sanction
  - No blame compensation
  - No need for criminal sanctions
  - Fair and just compensation
  - There will be a conflict between DOC and UK medical defence
  - There should be exceptions
  - Legislation cannot be a blanket approach – needs to include the exceptions

6. Would it ever be appropriate to apply criminal sanctions if the duty of candour was breached in this scenario? If so in what situation?

- Rationales given for a criminal sanction

  - Persistent mistakes leading to serious harm
  - Intentional hiding or covering up of information
  - If there is concealment and destruction of information
  - Malicious deliberate intent
  - Repeated offence
  - Yes – but organisational responsibility
  - If there is abuse of position or care
  - If evidence was falsified
  - If there were multiple incidents
  - Depends on the level of severity of the case
  - If the process has not been followed
  - There should be levels of criminal sanctions
  - If there is poor practice
  - Only following a thorough investigation
  - If it is a safeguarding issue
  - Wilful neglect
  - If there is sloppy practice, system issues, capability issues and malicious intent
  - Organisational sanctions are appropriate (not individual)
  - Severity
  - Why is NI different?
  - Criminal sanctions should be used equally across society – politicians etc.
  - If there is an absence of learning
  - If there is a failure to investigate

- <u>Rationales given for not applying a criminal sanction</u>

  - If a logical professional argument is given to withhold information
  - If you can provide evidence of your decision making
  - If you accept your mistake and there is a context for it
  - Professional or organisational measures are enough
  - Organisational responsibility vs individual
  - Not if there is a clear rationale and intention about why candour was not exercised
  - If it was not intentional cover up
  - Depends on the level of intent – professional standards cover that
  - Depends on the seriousness of the consequences
  - Clarity on the differences between criminality and professional negligence
  - Some sanctions appropriate – not necessarily criminal
  - Need to look at the system – organisational duty appropriate
  - Thin end of the wedge
  - NI would be different to the rest of the UK
  - People are only interested in criminal prosecutions
  - Impact on positive culture
  - Staff already under threat of criminal sanctions – this would be another
  - The fear of a criminal sanction would be an impediment to a duty of candour
  - In social care it would be difficult to find out what happened
  - Using a hammer to crack and egg

7.	**At your table, what is the one big idea for how we can keep you and others involved in taking this work forward?**

- Ongoing communication as the process goes on
- Use trust bulletins
- Blog on trust intranet / website /SharePoint
- Social media
- 2 way communication and feedback
- Open forum and feedback
- Interactive sessions with staff – lunchtime/MDT involvement
- Important to involve all grades of staff
- Duty of candour champions to lead engagement programmes with staff
- Communication from the top of the organisation
- Active training for staff
- Careful with language – people don't understand duty of candour
- Direct communication from the department to the trusts
- Split and further sessions
- Advertise better - more notice
- Local events

- Students and frontline staff involved
- Really listen to what staff are feeding back
- Case study approach
- Accommodate shift work
- Create an app / podcast/ chat forum
- Coproduction approach
- One stop hub for DOC information
- Lose the intimidating jargon
- Use the patient voice / videos etc.
- Involve professional bodies and trade unions

APPENDIX 1.3 Summary of Third Sector views on Duty of Candour & Being Open

IHRD What does a Duty of Candour mean for Health and Social Care?

SUMMARY of FEEDBACK

Third Sector Involvement events

Introduction

NICVA has been engaged by the Department of Health to support the meaningful involvement of the third sector. NICVA will host two events with the third sector, entitled 'Transforming Health Through Openness and Candour':

- 27 June 2019 (approximately 60 attendees)
- 30 September 2019 (9 attendees)

Event Format

An **introduction** to the Hyponatraemia Inquiry was given to provide an overview and background to the programme of work. Attendees at the event heard from:

- Fergal Bradley, IHRD Programme Manager, DoH
- Peter McBride, Chair of the Being Open sub-group
- Seana Talbot, Vice-Chair of the Being Open sub-group (27 June event)
- Quintin Oliver, Chair of the Duty of Candour Workstream (30 September event)
- Geoff Nuttall, Head of Policy & Public Affairs, NICVA

Two workshops – 'Being Open' and 'Duty of Candour' – formed part of the event. Attendees were asked to list the challenges and benefits of each and provide recommendations as to how those challenges can be overcome. Each of the tables at the event was independently facilitated. An event report was developed by NICVA which provides a full breakdown of what was said at each table can be viewed in the Event Report, a summary of which is set out in the following sections.

NICVA would like to place on record its thanks to the facilitators, the Department of Health, the event speakers and particularly those who attended and contributed to the event. A list of attendees is provided in Appendix 3.2.

1.3 Part A: Third Sector Group work questions: BEING OPEN

1	What does being open look like?

- <u>Communication</u>
  - Accessible, simple information – proactively given

- Honest communication – not withholding or concealing
- Person centred
- Clear policies and procedures – clear management of expectations

- Open Culture

  - Those who do the right thing are protected
  - Culture of communicating openly always – not just in a crisis
  - Openness is affirmed not punished
  - Leadership models openness
  - Full information on what is available to people – those who deliver and those in receipt
  - Responsibility, not hierarchy – needs to be cyclical

- Learning

  - Open to learning and communicating
  - Learning when things go wrong
  - Staff being confident to have difficult conversations
  - Staff understanding the parameters
  - It should apply across the board – a bottom-up, top-down approach
  - Culture of learning, not blame or fear

- Issues specific to the third sector

  - Fear of losing funding when being open about problems
  - Need a supportive response rather than punitive when things go wrong
  - Power imbalance in contract relationships. Impression is “we’re judging you, and we’re perfect”.
  - Is being open any different to what it looks like for the statutory sector?
    - Morality
    - Good practice and record keeping
    - Easy to make a mistake
    - Training
  - Open information sharing between organisations
  - Openness in voluntary and community sector often hits a barrier in relation to working with the statutory sector
  - Power is with the HSC
  - Professional arrogance
  - Service agreements vs contracts
  - “We” are perceived to be more accountable than the statutory sector
  - Need to know – not included in sharing information
  - Partnership only when it suits

- Fear of consequences – contracted services and impact of disclosure – funding implications
- Funded to be open / realistic understanding of costs
- Proud of openness but can be difficult to tell how message is received by the HSC
- Risks when being open:
    - Challenging experience
    - Reputation
    - Individuals/organisations Versus statutory agencies
    - Irritant to the system
    - Not even playing field
    - Funder experiences – payment
    - Delivering tenders – involvement to help shape tenders based on need
- Voluntary and community sector organisations are already open and transparent
- Knowing the limitations of the expertise of the voluntary and community sector organisation – they only know what they know within their field

2	**What are the benefits and challenges from an open culture?**

- <u>Benefits:</u>

    - Inspires confidence and trust in the system
    - Enables truly person-centred services
    - Enables true partnership working / co-production
    - Enables real learning from mistakes
    - Enables real accountability
    - Improves quality of care
    - Boosts confidence and morale and alleviates fear in staff
    - A rights-based approach to services
    - Reduces bureaucracy
    - Shows leadership
    - Feeling of being a lead partner in our own care
    - Increased motivation
    - Feeling of being listened to/being involved
    - Culture – Media 'Fake News'???
    - Provides a foundation for providing support throughout organisation especially staff
    - Advocacy role of third sector
    - Learning, growing and responsive organisation
    - Better outcomes for patients & health service
    - Issues can be addressed in a wholesome way for all concerned
    - Successful process of change
    - Increased trust
    - Trust of senior users/Good reputation
    - Creates trust within a team
    - Creates Trust

- Patient feeling safe and secure in the knowledge of their condition and care plan
- Trust in care providers
- Better service delivery, based on all information
- Reduction in inappropriate referrals
- Better risk management process
- Consistency across services whether that's in the Health Trust or the Third sector
- Safety and best practice for service users and staff
- More joined up approach and working together leading to stronger and easier referral pathways
- Safe and informed support for service user and care provider
- Patient being more engaged service user in their care plan/journey.

- <u>Challenges:</u>

  - Openness needs to be embedded right from the start of careers – at recruitment
  - Diverse culture and varying religious beliefs. Moral issues – people feeling judged on their beliefs?
  - Lack of shared power – third sector deemed powerless
  - You might need to tell the service user something they do not want to hear
  - Fear of prosecution or loss of contract
  - Public sector do not understand the professionalism within the third sector
  - Arrogance toward voluntary sector from statutory sector
  - No point in candour if changes aren't implemented in the wider system – 'tokenism'
  - How are people treated if they are candid about a service that isn't working well?
  - Fear of litigation/being sued, losing job, of blame, others' perceptions
  - Policy and procedure limitations e.g. GDPR
  - Not enough support and training for staff
  - Fear of families going public – social media
  - Need to improve the skills of contract managers
  - Being health sector led. This needs to connect to wider civic society
  - Giving staff protection and ownership around openness
  - Addressing power imbalance in a hierarchical and defensive HSC system
  - Being honest. People afraid to speak out – fear of repercussions
  - Carry the risk – partnership with third sector/HSE to carry the risk
  - Expectations
  - Voluntary not amateur
  - Reputation
  - Reaching into communities
  - Fear/Fear of repercussions
  - Expectations – resourced, support staff, policy development, open and transparent that third sector need to do
  - Power balance/in balance
  - Increased risk averse style
  - Payment of suitable staff with responsibilities in this area

- Voluntary does not mean unpaid. Standards/Professional
- Huge challenge to change culture of a massive system
- Risk to reputation
- Current culture of underestimating capacity of patients to speak for themselves
- Danger of violating confidentiality esp. in counselling situation
- Getting past the G.P. receptionist
- Time- GP appointments on 10 minutes
- Staffing levels- patients unable to see consistent healthcare staff
- Fear
- Support for staff not being consistent or authentic
- Limited resources
- Leadership buy-in
- Challenges of staff being open to a change in culture
- Having to deliver difficult information to service user – how is this done? Need for training & support
- Having to 'grass up' service user
- Understanding of GDPR amongst healthcare professionals
- Multi-Discipline teams' relationships and viewpoints
- Contractual challenges vs Best Interests viewpoint

3 How do we overcome the challenges?

- Appropriate training – targeted and specific
- Review policies and procedures – investment in resources
- Leadership and development
- Enforcing a duty of candour, e.g. fines and penalties
- Support for staff
- Basic 'Bill of Candour', much like a Bill of Rights, on display in every building where care is delivered
- Link to HSC transformation
- Needs to be distinct from an Equality Impact Assessment
- A 'Department of Candour' – holding organisations to account on the issue
- Needs to be a relationship between 'being open' and safeguarding
- Need to manage the treat of punitive action carefully, so not to overburden employees
- Protection of workers' rights and staff training
- A change won't happen 'accidentally' in the sector. Need support at different levels
- Learning culture rather than blame
- Sharing amongst team: 'what can we do better?'
- Easy reads and translations or say it as it is! No jargon
- Absence of fear
- Clear, defined processes for being open when something goes wrong
- More face-to-face contact

- SAI, or something similar, to report incidents
- Ombudsman and legal requirements as part of a complaints procedure
- Regulations to have the opportunity to get things right and improve patient confidence
- 'Speak up safety guardians', NHS England – model for NI!
- Need for an independent structure to raise issues of openness
- Actively monitoring when openness fails to happen
- HSC providers from all sectors should sign-post to independent advocacy services and should be embedded as a policy early on
- Leadership
- Resources
- Value properly acknowledged
- Adequate funding
- Candid conversations about scope of services
- Clear definition of partnership between statutory & voluntary sectors
- Training
- Clear language & meaning understood
- Partnership – service user/person receiving care is in the lead
- Openness & confidentiality working in tandem. Clarity.
- Consent. Empower clients
- Organisations could undertake baseline assessments into the culture of their organisations- requires organisations to be honest with themselves
- Bottom up & top down approach
- Ensuring that third sector organisations are actively included in discussions about a patient's care, respecting and acknowledging the role of these organisations and providing them with the relevant information in a timely manner to enable them to actively participate in discussions.
- Investment in the form of money, time, staff training and support, developing procedures, reconfiguring systems, cultural shift
- Ensuring active involvement of leadership
- Ensuring that there is accountability for leadership and providing a mechanism for staff to feedback to leadership
- Discussion about being open with everyone- is there information that could put someone at risk? i.e. cases of domestic violence, safe-guarding children and vulnerable people.

APPENDIX 1. 3 Part B Third Sector Feedback Duty of Candour

1.3 Third Sector Group Work Questions: DUTY OF CANDOUR

4	Benefits/disbenefits from introducing a duty of candour?

- Benefits:
    - Staff more protected if a duty of candour is in place
    - Challenges a culture of blame
    - Improves confidence in the system
    - Honesty produces learning – therefore fewer mistakes and improved services
    - Empowers people to be more "human"
    - Legislation holds us all to account
    - Better distribution of power
    - Demonstrates importance of candour – more than simple guidance
    - Will drive behavioural change

- Disbenefits:
    - Increased risk of litigation
    - More pressure on an already under resourced system
    - Will promote defensive/risk averse practice
    - Will increase fear of blame
    - Will make it less attractive to work in HSC – lower retention and recruitment
    - More bureaucracy
    - Challenge for third sector to train staff in time
    - Issue of additional cost – how will it be resourced?
    - Another level of fear for the employee
    - How will it impact volunteers?
    - Is it too big a thing to implement?
    - Legislation could be unwieldy and cumbersome with a slow timeframe
    - Case law might weaken a duty of candour

5	Overcoming the challenges

- Cultural change needed
- Needs to be cross-departmental
- Using technology to share information
- Needs to be well communicated – it needs to be an enabler rather than a burden

- Staff need to know they are supported to be open and honest
- Training
- A regulation that focuses not only on WHO but WHY
- Support for whistle-blowers
- Evidence/opportunity for learning
- Establishing a 'Healthcare Safety Investigation Branch' like in England
- Appropriate guidance alongside the law to ensure proper implementation
- Awareness-raising through all avenues, e.g. social media in an independent and well-funded way
- Challenge hierarchy and the 'god syndrome' within HSC
- Independent and well-funded advocacy scheme
- Statutory duty to co-operate
- Payment for training – resources are required
- Level of expectations to be managed at the early stage of process. Open and honest conversations to be held
- Independent voice required
- Code of Practice on a Duty of Candour – makes it easier to hold each other to account
- Public awareness
- Learning from other jurisdictions, no point reinventing the wheel
- Policies and procedures give reassurance. Regularly review
- Engage carers in a clearly defined way. Listen to carers – what do they want to see?
- We need an effective and functioning government. But we can engage with MLAs even if government isn't functioning
- Encourage difficult conversations within organisations

APPENDIX 1. 4 Summary HSC staff views on Event Organisation

IHRD What does a Duty of Candour mean for Health and Social Care?

SUMMARY of FEEDBACK

6 events took place throughout Northern Ireland reflecting the Health Service Trust areas

- WHSCT - Waterfoot Hotel 45 attendees
- NHSCT - Dunsilly Arms Hotel 80 attendees
- SEHSCT - The Pavilion 88 attendees
- SHSCT - Craigavon Civic Centre 82 attendees
- WHSCT - South West Acute Hospital 39 attendees
- BHSCT - Grosvenor House 67 attendees

Participants: 401 staff attended events comprising - 147 nursing; 57 admin & clerical; 38 medical/ dental; 18 multi-professional; 18 scientific/technical; 12 support/user experience; 6 ambulance; 6 senior executives and the remaining 65 participants unspecified.

Event Format

An **overview** was given of the recommendations of the Hyponatraemia Inquiry relating to duty of candour and Being Open, and an overview of the process of the Implementation Programme and the co-production model. The introduction ended with recordings of Dr Dermot Hughes, Medical Director, WHSCT and Maria Somerville, Carer, workstream member, speaking of their involvement in the implementation programme, and a film from the SHSCT about how a serious adverse incident was handled from a family's perspective.

The work of the **Being Open workstream** was presented its relationship to a statutory duty of candour. This focused on cultural change within the health service to a more open system and the opportunity to implement these changes quickly compared to the longer timescales associated with the introduction of candour legislation.

At each event staff worked in groups to discuss a number of case scenarios and consider questions in relation to the duty of candour and being open. A summary is set out below.

The views and comments of participants was aggregated to identify common themes in respect of the:

- Structure and organisation of events;
- Process and experience during the events;
- Outcomes of the events regarding candour and being open;
- Other issues that emerged during the workshops.

1.4 HSC Staff views on Event Organisation

1.	Structure

Feedback from every workshop commented positively on:

- **Composition** of the group and the need to have multi-disciplinary engagement with clinical and non-clinical staff at different grades
- Workshop **format** that started with informative presentations followed by small group exercises and large group feedback
- **Case studies** allowed participants to work through examples in a non-hierarchical way
- **Interactive approach** highly engaging with table hosts engaging participants at an individual level and facilitation for large group discussion and use of **technology** to speed up feedback and understanding
- **Logistics** worked well for local venues, accessibility, timing of events and time keeping on the day as well as email circulation of information in preparation

Areas for improvement – set out in order of frequency mentioned:

- **Participants** - open event to wider participation e.g. 'frontline' and medical staff
- **Discussio**n - More open floor discussion for wider questions and discussion
- **Case scenarios**, particularly from organisations where duty of candour is working
  - Giving more time to work through complex scenarios
  - Information on possible answers to scenarios
  - Wider range of scenarios to represent different practices
  - Grouping participants for discussion on specific scenarios
- **Candour** - more detail in the presentations particularly in relation to legal aspects and criminal sanctions
- **Service user** inputs during the events to be included in discussions
- **Language –** less jargon and less intimidating questions
- **Practical** improvements: greater notice of the event; agenda circulated in advance; acoustics and room temperatures in some venues; case scenarios and questions on tables; food and coffee provided as participants had travelled; directions and parking

2.	Process

Many commented positively on the process:

- **Rapid feedback** and data capture highlighted as a key success factor with good use of technology (Mentimeter system and word clouds particularly mentioned)
- **Open** and honest discussions, non-hierarchical, heard different perspectives

- **Shared learning** approach with time to reflect and listen as well as talk safely in small groups, hear other views and develop discussion on what candour is
- **Service user viewpoints** emphasising the relevance of openness and candour
- **Case scenarios** discussion linking to candour with good ideas in the room
- **Co-production** - engaged and felt included in developing ideas and involved in consultation
- **Balance** between inputs and discussion, covered a lot of work in a short time

Areas for improvement – set out in order of frequency mentioned:

- Seeing all the other **case scenarios** to understand feedback; more time to discuss case scenarios; videos to highlight service user perspective
- **Open** and honest discussion
- System for **ongoing discussion** and engagement with other Trusts and specialty groups
- **Preparation** by advance discussion between participants
- Continue as a **co-production** process/ need to understand how to influence/ voting on the way forward

3. Outcome

The outcomes most commonly mentioned in feedback were:

- Stress on **openness** and not just candour
- Understanding the importance of **being open** and admit when you don't know
- Understanding the **duty of candour** and different groups perspectives
- Starting to understand the **legal obligations** and telling truth with integrity
- Starting to think about the **barriers** to candour – the beginning of a journey
- **Shared learning** across all sectors that we are all human - It's ok to make mistakes but we must learn from them and realise we're all in the same boat
- **Participation** in the workshops was beneficial – even if didn't expect it to be so thought provoking – only starting to see the complexity
- Looking forward to the **next events** and being updated on duty of candour work

Areas for improvement – set out in order of frequency mentioned:

- **Communication** of key messages to all staff
- **Training** – included in induction and mandatory training for all staff/ leadership teams
- FAQs and **brief updates**/ information on work of DoC and Being Open/ feedback from workshops to participants
- **Follow up discussions**/ meetings and putting things into practice
- Keeping people motivated to do the right thing; guides/ tools to assist in spreading the word
- Need greater understanding of **legal requirements** and threshold

4. Other Issues

Other issues identified by participants:

- **Training** and development needs to be for all staff
- **Fear factor,** increased when staff under informed and don't know what to do
- Concerns about **criminal sanctions** and impact on health service and Trusts 'throwing people under the bus" in individual duty
- **Feedback** from one Trust more negative comments than from any others
- **Facilitation** mentioned positively

Areas for improvement – set out in order of frequency mentioned:

- **Local Assembly** – understanding how things will move forward (or not)
- **Funding** for local management to support staff and give feedback
- Re-run events once **decisions** have been made/ need to keep interest
- Concern this is just a listening experience **without influence**
- **Recognition** of what has already been put in place since IHRD investigation to promote openness and candour
- Greater appreciation about **realities** of delivering a clinical service and current pressures
- Concern that whistleblowing exists and DoC may **cause harm**/ trauma

APPENDIX 1.5 Summary Independent Health and Social Care sector views on Duty of Candour and Being Open

IHRD What does a Duty of Candour mean for Health and Social Care?

SUMMARY of FEEDBACK

Introduction

1 event took place which invited independent health and social care providers.

Participants

27 participants attended the event comprising – 1 owner; 2 Chief Executives; 5 Directors; 2 Heads of Service; 15 Managers; 1 Nurse and 1 Graduate.

Event Format

An **overview** was given of the recommendations of the Hyponatraemia Inquiry relating to duty of candour and Being Open, and an overview of the process of the Implementation Programme and the co-production model. The introduction ended with a film from the SHSCT about how a serious adverse incident was handled from a family's perspective.

The work of the **Being Open workstream** was presented and its relationship to a statutory duty of candour. This focused on cultural change within the health service to a more open system and the opportunity to implement these changes quickly compared to the longer timescales associated with the introduction of candour legislation.

At the event participants worked in groups to discuss a number of case scenarios and consider questions in relation to being open. These are summarised below.

1. What does an open organisation look like for staff working in the Independent Health and Social Care sector?

- <u>Culture</u>
  - absence of blame/fear
  - acknowledge when things have not gone right
  - approachable
  - challenge welcomed
  - partnership and coproduction
- <u>Regulation</u>
  - appropriate regulation

- change as a result of openness
- confident engagement with regulation
- inspections and regulation can't restrict openness
- positive engagement with regulators

- Leadership and Management

  - Clear vision from management
  - Communication up and down organisational structure
  - consistent bottom to top
  - different tiers of staff may have different responsibilities
  - Don’t tell staff what you think they want to hear
  - Managers visible and approachable - open door policy
  - Well led open culture

- Administration

  - clear guidance
  - Clear language to ensure full understanding
  - Clear understanding of processes and procedures
  - Clarify whistle-blowing
  - Staff meetings and communication, staff meetings, newsletters
  - Staff support
  - Staff want to be listened to
  - Welcome to staff with good induction

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

- Culture

  - absence of defensiveness
  - clear expectations and language
  - advocacy
  - concerns acted upon and result in change

- Making a complaint

  - Easy to make complaint
  - Families know who to speak to for complaint – point of contact
  - feedback on action taken
  - given guidance for support
  - honest two-way conversations
  - Involve immediately in managing risks
  - Keep families informed of decision-making process

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

- Nature of Regulation
  - absence of context in investigations
  - Different policies i.e. RQIA, HSCB
  - heavy-handed/inappropriate regulation
  - joint working between providers and regulation
  - One size fits all approach
  - RQIA - aggressive regulation and inconsistencies
  - RQIA is not about improvement
  - paternalistic approach
- Fear
  - disproportionate disciplinary actions
  - fear of blame
  - Fear of damage to reputation
  - Fear of losing job
  - Fear of speaking out
  - media response to an incident
  - police involvement in safeguarding issues
- Leadership
  - Openness for managers and also owners
  - absence of leadership at top
  - blame culture exists
  - Busy management
  - Lack of management skills
- System
  - absence of whole system approach
  - Balance of work and duties - unrealistic goals and expectations from management and relatives
  - Trusts contract on a budget basis so times with clients are squeezed (dom care)
  - Voluntary sector sometimes undervalued by Trusts
  - Resourcing constraints
  - system works against your nature/job to care
  - tick box culture
- People
  - absence of trust
  - aggressive patients and relatives

- Bad press fear
- don't hear good stories in media
- Lack of communication
- Staff attitude - disengaged

- Legal

  - case law would show that an apology is an admission of guilt
  - contracts via BSO with independent providers
  - relatives - high expectations and litigious

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

- Leadership and management

  - Accountability by management as well as staff
  - Good management - leading by example in relation to open culture
  - better staffing ratios
  - Better use of resources
  - Trust around whistleblowing policies

- Contracting and regulation

  - Assistance from RQIA
  - better contracts based on care rather than budgets
  - Challenge perception that home owners are hiding issues
  - Consistent approach to reporting and oversight
  - Greater authority for providers to operate safeguarding process
  - Greater focus on improvement rather than regulation
  - Joint working between providers and regulators
  - Partnership approach by RQIA
  - Partnership working with SAIs
  - Partnership with regulators and police to be open

- Role of service users and relatives

  - Role for relatives in strategic planning
  - more information for relatives regarding expectations
  - open conversations with citizens about what they can realistically expect from health and social care
  - Patient responsibility when receiving care
  - Sanctions to family members
  - Review meetings with families to manage expectations
  - Wider issue of blame culture in NI

Future Involvement

1.	**What is your one big idea for how we keep you and others involved in taking this work forward?**

- Be open and honest.
- Listen.
- Email bulletin with link to further information.
- Event update.
- Regular feedback by email or engagement events.
- Demonstrate what has been done.
- Important to engage at business owner.
- Better promotion of how to get involved.
- Regular updates.
- Individual link person within the DoC w/s to speak to about this when talking to staff.

Event evaluation

2.	**What worked well about today's session?**

- Refreshing approach, liked involvement of someone with operational experience in the sector (Peter).
- That there was a good range of different providers to give various perspectives.
- Method of collecting information saved repetitive feedback.
- Engagement.
- Peter, a very motivational speaker.
- Someone doing the technology part.

3.	**It would have been even better if?**

- Longer discussion- felt a little rushed.
- Input from either Trusts or RQIA.
- RQIA and Trusts were present.
- Dom care/Support workers should also take part.
- Further involvement as process develops.

APPENDIX 1.6 Summary Private Healthcare Providers views on Duty of Candour and Being Open

IHRD What does a Duty of Candour mean for Health and Social Care?

SUMMARY of FEEDBACK

Introduction

1 event took place which invited private healthcare providers.

Participants

4 participants attended the event comprising – 1 Consultant; 2 Managers and 1 Nurse.

Event Format

Due to the low numbers, an informal approach was undertaken to engage the group. An **overview** was given of the recommendations of the Hyponatraemia Inquiry relating to duty of candour and Being Open, and an overview of the process of the Implementation Programme and the co-production model. The introduction ended with a film from the SHSCT about how a serious adverse incident was handled from a family's perspective.

The work of the **Being Open workstream** was presented and its relationship to a statutory duty of candour. This focused on cultural change within the health service to a more open system and the opportunity to implement these changes quickly compared to the longer timescales associated with the introduction of candour legislation.

At the event participants worked in groups to discuss a number of case scenarios and consider questions in relation to being open. These are summarised below.

Being Open

1. What does an open organisation look like for the Private Healthcare sector?

- Communication
  - comfortable say anything
  - communication promotion duty of candour practice
  - easy to report concerns
  - awareness raising around openness
  - bottom up top down
- Actions
  - concerns addressed when reported
  - direct engagement when incidents occur
  - event reporting – anyone any time
  - process investigation openness embedded
- Staff
  - engagement staff, feedback exit interviews
  - leadership openness management
  - staff able report concerns
  - staff feedback and hearing learning outcomes incidents
- Accountability
  - regulated RQIA
  - regulation improve patient safety
  - requirements adhere good medical practice
  - visible openness amongst management senior middle managers

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

- Clarity about acknowledgement and apology
- expectational difference when paying procedure – higher standards? More timely, more patient centred
- clear expectations about what will happen and how with good communication
- informed when things go wrong
- patients told processes
- private sector elective work, lower risk, problems easier identify, obvious when things go wrong
- regular communication

3. What are the obstacles/barriers to being open?

- absence of feedback
- difficulty framing learning positively
- fear/ lack of trust
- media, social media, appetite bad news
- personal liability consultant
- reputational risk
- poor communication
- Resources/targets/time-pressures

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

- absence blame - favouring learning
- communication senior staff / senior staff visibility
- culture of regular feedback to staff and staff feedback welcomed
- engaging staff / staff meetings
- learning from incidents, complaints
- organisation demonstrates openness and takes responsibility
- whistleblowing responded clear protections

Duty of Candour

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

- duty is clear, evidence obvious, level of harm caused
- external referral professional regulators following investigation establish context
- meaningful
- patient
- report organisations incident system medical director
- RQIA

6. 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?

- both
- consultants treated part team
- individual duty easy, organisational harder achieve
- statements involved inform organisational response

7. What current statutory responsibilities/Professional standards/Guidance would apply? For example Consent, Capacity, Existing Trust guidance etc

- incident reporting system
- insurance
- Medical Advisory Committee
- professional Duties
- RQIA
- Whistleblowing

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

- apportioning blame to individuals
- reputational damage limitation
- trust

9. What can be done to overcome the barriers?

- engage with patients
- feedback incidents
- interpreters
- whistleblowing Northern Ireland, PROTECT, legal support needs provided staff

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

- covered up serious
- patients deserve know
- potentially place criminal sanctions
- where information withheld, no openness patient, no reporting, depending harm caused patient

Future Involvement

11. What is your one big idea for how we keep you and others involved in taking this work forward?

- maintain contact
- separate issues - independent /nursing residential sector

Event evaluation

1. What worked well about today's session?

- Opportunity to discuss case study
- Due to small group – very relevant to our Sector (Private)

2. It would have been even better if?

- Larger group would be better
- If more people were able to attend
- Larger group would have been useful but the small group was effective
- It is different from the public sector but having other hospitals would be good

APPENDIX 1.7 Summary service user and carer views on Duty of Candour and Being Open

IHRD What does a Duty of Candour mean for Health and Social Care?

SUMMARY of FEEDBACK

Introduction

This event was a follow up to the PCC Membership events held in May/June 2019. This event was designed to gain an understanding of the level of knowledge from a service user and carer perspective, input into the development of options and shape future involvement with service users, carers and the public. Participants included service users and carers involved across the IHRD programme and also people who had agreed to continue to be involved after participation in the initial PCC Membership events.

Participants

1 event took place, attended by 25 participants.

Event Format

An **overview** was given of the recommendations of the Hyponatraemia Inquiry relating to duty of candour and Being Open, and an overview of the process of the Implementation Programme and the co-production model. A service user and carer representative on the Being Open sub-group shared their experience of their involvement in the work to date and the importance of the service user and carer voice in this work.

At the event, participants were then asked a series of questions in relation to being open and candour. The first workshop considered what does Being Open and Candour mean for people who use HSC

services? Each table was then presented with a case study and participants were facilitated to consider further information in relation to what happens when things go wrong. This included asking participants to consider potential criminal sanctions as a result of action taken by staff. The next workshop asked participants to co-design survey questions to be included in the Northern Ireland Health Survey. The workshop concluded with participants sharing their views on the workshop set up and how this could be enhanced to further engage and involve service users and carers.

The workshop findings are set out below.

Workshop 1 – What does Being Open and candour mean for people who use HSC services?

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

- Communication Skills
  - active listening
  - empathetic – understanding the effect it has on the service user
  - carers listened to
  - fear factor
- Values
  - Compassion
  - Empathy
  - feeling trust
- Carers / Patients
  - consider person not partner family
  - share diagnosis treatment plan prognosis.
  - feeling organisation being open
  - If honest from start wouldn't happen
  - involvement children parents
- Actions
  - mystery shopper approach (peer review as well as external)
- Partnership approach
  - partnership between medic person carer
  - reflective practice needs time, can't be tick box
  - responsive individual needs empower service users carers involved care.
  - understand people's right know.

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

- Experiences
  - both sides valued feel valued.
  - co-designing survey users carers
  - kept informed
  - letter response issue / don't renege on agreed meetings

- Visibility
  - address individuals families/carer
  - aware non-verbal communication compassionate approach.
  - proactive involvement not reactive.
  - 3 monthly "take it to the top" meetings organisation leaders meet public
  - Advocacy
  - independent monitoring

- Training / skills development
  - Individual staff skills open conversations.
  - involve service users training staff
  - plain English

3. What support do people need?

- Independent Advocacy
  - completely neutral/independent
  - advice from multi-disciplinary teams
  - assistance with process and procedures
  - decisions taken patient representative present
  - independent department each Trust.

- Other organisations
  - confusion who does what? PCC, PHA or complaints department within Trusts

- Emotional support
  - consideration how people feel circumstances diagnosis treatment bad news.
  - emotional support HSC professional staff
  - sign-posting services counselling gain maintain trust.

- Practical
  - ensure safety remove danger.
  - establish personal needs around situation personal approach

- help navigate system
- help understand information
- keeping agreed times, no rushing. somebody close feelings high.
- English clear concise, no medical terminology

Workshop 2a When things go wrong?

4. What would you expect to happen?

- <u>Apology</u>
  - Say sorry
  - Apology
  - include apology.
- <u>Acknowledgement</u>
  - Acknowledge
  - consultant tell problem ownership mistake
  - fixing error care plan balanced view advice
  - open truthful tell patient regarding issue.
- <u>Involvement and communication</u>
  - arrange family meeting, time explain options.-consent adult patient.
  - benefits vs non benefits
  - committed truth patient family
  - consent form lists potential complications effects
  - explain options
  - honest timeline next steps.
  - told them approved carer
  - tell patient
  - significant other present post operation
  - patient opportunity express feeling allow reaction include time support.
  - patient first decision making.
  - patient first truth
  - continued engagement patient before during after
  - needs consultant responsible for care
  - options told patient informed decision
  - plan next-give choices
  - family something different patient
  - told not loop hole
  - assessment fitness further surgery option postpone.

- Investigation

  - investigation
  - expectation learning wider team
  - documented

- Feedback and learning

  - feedback
  - learning culture why learn
  - learning incident-positive negative
  - retrain clinicians, don't sack
  - GP made aware future problem know background

5. What information should be provided?

- Format

  - in writing
  - accept responsibility
  - include apology
  - written intervention decisions summarises bring someone talk through.
  - plan
  - plain English key terms written report.
  - Show information

- Explanation

  - explain process finding what happened.
  - explanation what went wrong.
  - facts
  - give patient all information- choices options.
  - options available
  - options available complaint investigation.
  - possible outcomes
  - told how -think before patient.
  - hospital paper always near miss incident.
  - research changes

- Involvement

  - join discussion consultant patient based
  - patient centre decision

- willingness understand how

6. When should it be provided?

- Timing
  - as soon as possible consider patients want involved.
  - give patient time reflection
  - information given asap Real time response.
- Communication
  - communicate manage expectations parameters.
  - mistakes detected information available, every stage
  - Responses
- Context
  - depends how long take them find out information
  - depends situation
  - immediate
  - implications when should know.
  - people know something's wrong
- Record-keeping
  - Important recorded notes.

7. Who should be providing it?

- Senior Staff
  - consultant
  - consultant
  - consultant ongoing engagement
  - consultant provide information; avoid accountability passed on.
  - consultant surgeon
  - consultant.
- Involvement
  - involve family carers
  - nursing staff

- Support

  - consider age patient-state of mind.
  - somebody trained to talk
  - independent support.
  - Person at the centre of error' with advocate.

- Learning

  - organisational learning, doesn't happen again.
  - team approach evidence learning, disseminate learning, feedback patient.
  - assurance regarding learning.

8. What support or assistance would you need?

- Advocacy

  - advocate
  - independent support advocacy
  - responsible advocate
  - patient advocate
  - supports

- Information

  - all information
  - Sufficient knowledge.

- Communication

  - clear obstacles judge openness
  - consistent communication.
  - Explain information
  - follow up opportunity discuss case
  - follow up phone call contact – proactive
  - feedback system patients.
  - form complete before leave – anything to discuss
  - information.
  - speaking language people understand.

- Families

  - consultation family support

- relative present
- written report

- Responsiveness

  - contactable.
  - assigned responsibility.

- Staff

  - senior nurse present
  - consultant surgeon
  - training staff undergraduate level, parental responsibility consent issues.

- Time

  - time consider
  - Time information.

Future Involvement

How should we engage with other service users and carers?

- 10,000 voices questionnaire on openness
- Ice breakers at table.
- Ask people involved to share.
- Inclusion on social media,
- Survey sent to anyone who has complained to NHS in last 5 years.
- More outreach i.e. GP/Dentists to ensure people are aware of your existence/what you aim to achieve.
- More group discussion
- Mixed groups of SU/C and professionals is good for discussion.

Workshop 2b Criminal sanctions

Each table was asked to consider a set of statements in relation to Being Open and a duty of candour and potential criminal sanction as a result of action being taken by staff. The following sets out table responses and comments received.

Action	**Potential consequence**
1. A member of staff forgot to record and share information in relation to a patient's treatment plan.	a. No action b. Training required to learn- **5 responses** c. Disciplinary action through organisation or professional body- **1 response** d. Criminal prosecution e. Other? Please share

Comments • Training should always take place in these situations. • If policy and procedures were not followed and with the view to ensuring it does not happen again. We recommend disciplinary action. • Criminal prosecution if disciplinary action suggested. It should be recorded for shared learning across the system. • Firstly, then evaluation of this. • Depends if it is a repeat behaviour. • Depends on the information. • Depends on nature of information. • Focus on learning not punishment. • Review systems- why did this happen? Are there pressures?	
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.	a. No action – **3 responses** b. Training required to learn – **1 response** c. Disciplinary action through organisation or professional body d. Criminal prosecution e. Other? Please share- **2 responses**
Comments • Enquiries should be made to ascertain who has made this mistake and where the notes have gone and why. • Ensure GDPR are met until notes are in the system-Accountability. • I.T. assurance has to be built into the system-this should trigger investigation/audit. • Need to bring patient back when notes are available. • Tell what they do know and what they don't. • Create an incident report when they become aware of this. • System looked at review- identify issue.	
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.	a. No action b. Training required to learn- **3 responses** c. Disciplinary action through organisation or professional body - **2 responses** d. Criminal prosecution e. Other? Please share- **3 responses**
Comments • Training on the procedure and on being open and honest for the clinician. • Other- has to be shared learning across the system, • Through both organisation and professional body. • Training to ensure this doesn't happen again-minor harm-harm is a subjective term, not to be afraid of having 'harm' conversations with patients. • Depends on nature of error- if it was a lie. If so, record centrally somewhere so that if it's repeat behaviour needs addressed. • Depends on response- between B & C.	

• Written up in there notes and recorded as an incident. • Ask the patient what they would like- to inform next steps in process.	
4. A GP receptionist forgets to issue an appointment letter and after the mistake is identified, the patient is contacted immediately.	a. No action- **5 responses** b. Training required to learn- **3 responses** c. Disciplinary action through organisation or professional body d. Criminal prosecution e. Other? Please share - **1 response**
Comments • Training is still appropriate • Investigation to see is this a trend or pattern for assurance. • Staff training in systems-training on how to own up quickly and be sure to apologise for smaller things to build public confidence. • Needs to be an apology. • Checking system, review procedures. • No action except as part of internal performance review- not about being open. • Between A & B. • Consider what happened as a result/ in the interim. • Use staff supervisions to identify if is a habit/one off.- • Support staff to do job. • Review training-is it needed?	
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.	a. No action b. Training required to learn- **1 response** c. Disciplinary action through organisation or professional body- **4 responses** d. Criminal prosecution- **4 responses** e. Other? Please share
Comments • Fraud/Falsification- shared learning required. • Criminal for actions regarding cover up. • Disciplinary to make sure professional body fit to practice and possible suspension/other sanction by employer. • May involve C&D • Start with C and depending on outcomes/findings move to D.	

Workshop 3 – Ask the public – co-designing a survey

Participants were asked to imagine if they are stopped in the street and asked to complete a questionnaire about openness in Health and Social Care. Responses to this question informed the Workstream in relation to the development of questions to be included in the Northern Ireland Health Survey.

Event evaluation

1. What worked well about today's session?

- Good discussion
- Good discussions
- Talking with other parents/carers
- Discussion with others
- Excellent facilitation
- Good craic
- Good cross section of people in the discussion.
- Good discussion
- Good meeting-well informed.
- Personal in small group
- Good discussion.
- Good meeting-well informed
- Table discussions/Hearing update from Peter/Fergal/Anne.
- An opportunity to engage with other SU/C.
- Venue good.
- Workshops very good.
- Group discussion
- Brainstorming
- Advertising documents to be published
- Lots of energy and enthusiasm.
- Explaining scope of duty of Candour
- Having a strong case study got us on the same page from the outset.
- Outstanding presentations.
- Peter and Anne were great speakers and very passionate.
- Good table facilitation.
- Several short workshops.
- Peter McBride talk about honesty and risks if lying.
- Aware that public can get historical medical notes of living and dead.
- Session work is good-bring out more in people.
- Group discussion-good mixture of professionals patients and carers.
- Building agreement around the table was a good way of working.
- Group conversation brings out more than a questionnaire-we bounced off each other.
- Good discussions with professionals/carers all singing from same sheet.

2. It would have been even better if?

- Come out to larger groups and talk about things/ask questions.
- Use of word parent as we are not a su/c.
- More time
- Sound
- IT poor.
- Sound
- Venue not good acoustically.
- More time.

- Sound
- Less time on presentations and more workshop time.
- Background noise drowned out discussions.
- Sound
- More time.
- Use of parent carer as we are distinct from carer.
- Presentations sound.
- Better venue/poor acoustics.
- Time for participants to consider the topic before the workshop.
- Too short.
- N more time/tables better placed.
- Sound - more question time.
- Sound and lighting could be better.
- More time needed.
- More time.
- Group needed more time.
- More time, a full morning on the design of the questionnaire.
- Being able to say things that reflect reality not theoretical position.
- Time to get to know the people and their experiences valuable insights shared.
- The opportunity to be open and honest about personal experiences.
- More time allocated to each discussion.
- Time pressured/stressful.
- Questionnaires should not be processed on the high street.
- We need to meet up with professionals face to face to hear their views and to give our own views/comments.
- Started late, Sound bad.
- Video didn't work.
- Video clips from Doctors.
- More time needed.
- More time.

APPENDIX 1.8 Summary Dental sector views on Duty of Candour and Being Open

IHRD What does a Duty of Candour mean for Health and Social Care?

SUMMARY OF FEEDBACK

Introduction

1 event took place which invited Dentists and Practice staff.

Participants

44 participants attended the event comprising – 36 Dentists; 4 Dental Care Professionals; 1 Dental Practice staff; 1 Dental Nurse and 2 participants unspecified.

Event Format

An **overview** was given of the recommendations of the Hyponatraemia Inquiry relating to duty of candour and Being Open, and an overview of the process of the Implementation Programme and the co-production model.

The work of the **Being Open workstream** was presented and its relationship to a statutory duty of candour. This focused on cultural change within the health service to a more open system and the opportunity to implement these changes quickly compared to the longer timescales associated with the introduction of candour legislation.

At the event participants worked in groups to discuss a number of case scenarios and consider questions in relation to being open. These are summarised below.

1. What does an open organisation look like for the Dental profession?

- Communication

  - All staff feel confident to speak up
  - 360 Feedback
  - Effective feedback
  - Equal opportunity to speak up
  - Staff can communicate regardless of hierarchy
  - No negative consequences to speaking up
  - Younger staff have confidence to speak up

- Culture

  - Casual and formal approaches
  - Access to management and they need to be visible
  - Approachable
  - Contributions valued
  - Lead members accessible
  - Minimising negative consequence
  - Learning encouraged
  - Non-hierarchical structure
  - Secrecy - don't want to be open due to how viewed from other dentists

- Structure

  - Openness more difficult in certain circumstances in smaller organisations as there is no 'hiding place' like in a bigger one
  - Protected time training learning
  - Practice manager in place
  - Regular consistent staff
  - Regular meetings
  - Regular staff appraisals
  - Regular staff meetings
  - Time for reflective practice within remuneration

- Patient involvement

  - Routine practice to talk to patients

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

- Patient experience

  - as a patient you want time spent on you
  - difficult to know as a patient how open an organisation is other than how you have been dealt
  - with discretion and privacy
  - don't want to be made to feel that you are a bother

- Feedback

  - free to ask questions
  - give options - tell everything
  - good records kept
  - if concern raised is it taken seriously and listened to
  - Know everything about treatment
  - Know how to complain
  - Patients have feedback actively sought

- Administration

  - Practice leaflet
  - Sharing appropriate level of information
  - Simple mechanism for patient feedback (did you get the care you provided?)
  - Suggestion box
  - Speak to the person with the information

3. What are the obstacles/barriers to being open?

- Protection

  - Absence of protection for making an apology
  - Ambulance chasers
  - Apportioning individual blame - being a practice owner carries extra responsibilities
  - Claims
  - It's not the patient who has been wronged who you are most fearful of - its regulatory and professional organisations

- Resources

  - Cost e.g. more time to explain
  - Dental practice a business
  - Indemnity - Lack of support for indemnity
  - Profit and target driven corporately owned practices
  - Punishment - financial or powers to restrict or close down
  - Resources for training
  - Time pressures to not be fully open

- Culture

  - Culture and language differences
  - Defensive hierarchies
  - If barrier is with principal dentist then much harder to implement
  - Little understanding on part of patients of complexity of practice and that things
  - can go wrong
  - Lots of pressure from patients expecting perfection and little expectation of error

- Specialist issues
    - Different medical conditions e.g. dementia
    - Language barriers – translation services
    - Personalities - relationship issues in small practice felt more than Trusts
    - Standard fee approach to remuneration

- Fear
    - Fear of aggressive regulation
    - Fear of GDC
    - Fear of lack of support
    - Fear of legal action
    - Fear of litigation
    - Fear of punishment
    - Potential of maliciousness

- Regulation
    - Over regulation rather than culture change
    - Regulation constraints

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

- Language
    - Access to interpreters but time burden
    - Interpreters service

- Resources
    - Better funding - more time
    - Better system of payment to allow for more communication
    - Fund dentistry properly
    - Increase remuneration
    - Move to GP model
    - Payment model needs to change so time can be freed to deal with patients
    - Paid for time rather than output
    - Remove liability/costs for overheads

- Regulation
    - Dentist-specific regulation
    - Clear pathway for patients to raise questions

- Remove punishment
- Removing blame culture

- Appraisals

  - Individual appraisals
  - NIMDTA staff as appraisers
  - Written patient information re treatment plans would save time

Future Involvement

5. Ideas for keeping you and others involved in taking this work forward?

- Small group discussions on online surveys.
- More meetings like this
- More info evenings or circulate more info to practices on how policy is developing.
- Further workshop.
- LDC meetings. – send reps to meeting.
- Others in practice wanted to come but no space. Free CPD workshops.
- A look at more of the detail.
- Involve us in selling this to the public and educating and motivating them to give in the space to change/transform.
- Other members of dental team such as practice managers and dental nurses.
- Encourage communication between G.P. S.D.P and hospitals.
- LDC- involve Trusts.
- Further workshops and materials for staff training re open culture and Duty of Candour.
- Follow ups-emails and more workshops.
- Seminars like this from time to time.
- Get more involved via social media. More nurses need to be active in these conversations.
- Email and feedback.
- Open social/communication platform for healthcare professionals.
- Email us with a summary (not 10 pages).
- Email us with a simple feedback option for us.
- Relay info to wider numbers of dentists. ULA – LDC-NIMDTA
- HSCB dental newsletter.
- Secure HSC emails for GDPs.
- LDC's
- The BDA is a trade union and a professional organisation and should be included in any work in this area.
- Practice based training.
- Updates by email.
- Another workshop.
- Online survey- training for CPD incentive?
- Future CPD workshops.
- Continue to keep primary care needs as part of the process.

- More training and awareness on subject. E.G support available for Dentists when things go wrong.
- Try and keep it simple so all staff can understand what DoH is trying to do.
- Discussion with Dentists and those that can make changes in regulations/contracts. Including wide range of primary care and secondary dentists.
- Update workshops-info through HSCB newsletter
- Email updates/Roadshows.
- Somewhere to check progress online.
- Small group discussions in different locations across the province.
- Online surveys.
- Opportunity for the profession to have increased representation I the relevant workstreams. Know what 'next steps are.
- Involve NIDPC/BDA.
- Do some work and get same group back in a few months time.

Event evaluation

1. What worked well about today's session?

- Well constructed and presentations and actually promoting openness in your style of presentations.
- Refreshments
- Discussion round the table.
- Format.
- Feedback arrangements
- Everything was good from the food to the presentations to the workshops. Just not sure if it should apply to primary care Dentistry-feels like overkill.
- Relaxed and open.
- Menti worked well, moving along at reasonable pace. Good to have a relevant case study.
- Small group discussion.
- Able to target feedback from a lot of people efficiently.
- Efficient – right amount of time.
- Open conversation.
- Open discussion with press.
- Excellent informative evening.
- Interactivity.
- Liked that you were able to talk openly in small groups.
- Felt you were being listened to- dentists are often forgotten.
- Facilitated discussion.
- Location.
- Excellent informative evening.
- Open discussion with peers.
- Open conversation.
- Efficient, right amount of time.
- Enjoyed interactive nature and hearing other people's views.
- Open, useful, informative.

- Discussion with colleagues.
- Good interaction in the group.
- Discussion with groups.
- Specific dental examples.
- Group discussion- enough time to share experiences and thoughts.
- Interactive small group discussion.
- Smaller groups.
- Interaction with other professionals I have never met before.
- Dental scenarios.
- Not yet thrust down our throats.
- A person to take notes.
- Group chat, nice to hear others opinions, including more experienced dentists.
- Interactive and ability to discuss ideas in small groups.
- The electronic feedback mechanism.
- Good to chat in small groups.
- Facilitator.
- Discussion with colleagues on forming future guidance.
- Interactive.
- Enjoyed the workshop consultation.
- Good to meet other dentists and hear their views.
- Opportunity for discussion in an open environment.

2. It would have been even better if?

- Further meeting when guidance produced.
- Define exactly what might constitute criminal sanction.
- We as dentists in N.I. are most definitely regulated in UK. We do all of this already so do not make it over onerous.
- It would be interesting to mix our groups within primary care, opticians and pharmacy.
- Different locations for events.
- Involve more dental nursing staff/admin staff.
- IT system allowed summary feedback.
- Should be able to pick your own table.
- Copies of slides provided.
- Briefing being sent in advance.
- Content made more accessible./relevant to GDP's.
- IT fully functional (although basic premise good).
- Assumption made that we are not open.
- Include younger dentists. Tend to get 40+ opinions.
- As well as facilitator, someone dental to lead conversation ensuring discussion on correct topic.
- Paperwork before hand to allow us to think over issues prior to evening.
- People who have been involved in SAI's as the clinician should be able to reflect their story as to how it would have been different in new culture.
- More team based.

- Scenarios with different answers and options.
- Follow up to ideas.
- More scenarios.
- Coffee break to get a cup of coffee- not for long.
- Room cooler.
- More discussion around resolving specific dental adverse incidents.
- Different location.
- Needs to be a better understanding of how general dental practices operate and the challenges these small practices face in reality.
- More time to discuss topics. Too many questions.
- Introductions lengthy-Shorten.
- Swap scenarios to answer in different circumstances.
- Dentistry (NHS) funded properly not just patched with commitment payments.
- 3 hours would have made it better.
- Have workshops during 9-5 hours and be funded.

APPENDIX 1.9 Summary Social Care Managers views on Duty of Candour and Being Open

IHRD What does a Duty of Candour mean for Health and Social Care?

SUMMARY of FEEDBACK

Introduction

3 events took place throughout Northern Ireland to engage the Social Work sector in preliminary discussions about being open and a duty of candour. The Northern Ireland Social Care Council engage with the social care workforce in a variety of ways. This includes annual conferences and also via on-line technology known as the ECHO project.

As part of the Social Care Managers Forum annual event, an introduction to Being Open and a duty of candour was presented.

As part of the ECHO project for Social Care Managers, an interactive workshop was undertaken.

Information gathered from these events will assist to lay the groundwork for future involvement activity aimed at the social care workforce, to ensure moving forward they are meaningfully engage as part of the programme of work.

Participants:

- Social Care Managers Forum – Autumn 2019 event – 6 November 2019 – Omagh – 65 attendees
- Social Care Managers Forum – Autumn 2019 event – 7 November 2019 – Antrim – 120 attendees
- ECHO Project – Social Care Managers – December 2019 – 16 attendees

A Social Care Managers Forum

Event Format

An **overview** was given of the recommendations of the Hyponatraemia Inquiry relating to duty of candour and Being Open, and overview of the process of the Implementation Programme and the co-production model.

An overview of the recommendations was presented relating to the introduction of a **statutory individual and organisational duty of candour**, with consequent criminal sanctions. Discussions of the workstreams' process, the work done so far and contextualising the introduction in light of existing professional regulation.

At each event staff were asked:

1. What is the most important element of this for you? and
2. How should we engage and involve the social care workforce?

The responses to these are summarised below.

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

- Importance of Routine Openness
  - Openness should be the norm all the time

- Accountability and Management
  - All are held accountable for openness throughout the organisation
  - Managers lead by example
  - Staff who show openness are supported by managers
  - Need a support system in place for staff who want to disclose
  - Workloads are managed to allow for openness and reflection
  - Manage whistleblowing properly
  - Proper implementation process for duty of candour

- Learning culture
  - Not a blame culture when things go wrong – rather a learning culture
  - Learning disseminated across all trusts
  - Create a safe environment without fear of legal repercussions
  - Create culture where staff get used to getting feedback about how they're doing
  - Routinely candid – not just when things go wrong

- Active engagement with staff and service users
  - Proactive outreach to service-users
  - Active engagement with staff to reflect on their practice, and
  - Discuss mistakes without fear of repercussions

- Apology
  - Its ok to say sorry

Future Involvement

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

- Direct Events
  - importance of face to face engagement
  - roadshows with examples of what to do when things go wrong
  - Awareness sessions
  - Learning from mistakes – case-studies
  - Outside own organisation – learning with others
  - Use case studies – examples of what to do when things go wrong
- E-Learning
  - Accessible online
  - Consultation via email
  - Create online forums
  - Website link where people can put forward questions or concerns
  - Provide written guidelines
- Create a being open task-force
  - Draw from representatives of all organisations
  - Meet monthly
  - Gather ideas about how to successfully implement
- Create being open forums for all staff discussion
  - Regular meetings for discussion
  - How to incorporate successfully
- Incorporate into professional supervision
  - Reflective practice in personal supervision
  - Regular, frequent group reflection on practice issues
  - Multi-disciplinary reflection groups
- Whole workforce involved
  - Top down
  - Should include all managers
  - All staff face to face meetings to discuss implications
  - Promote training – NVQ/QCF level 2/3
  - Face to face workshops with employees/senior managers co-hosting
  - Multi-disciplinary focus groups to discuss implementation

- Incorporate into social care professional standards

  - Incorporate into all processes especially team meetings, supervisions and appraisals.
  - Incorporate into social care standards
  - Incorporate at induction
  - Incorporate in to training and registrations processes

- Involvement of carers and family

  - Direct engagement with carers
  - Leaflets and information for carers and family

- Open acknowledgement of the challenges and fears

- Use the NISCC registration process

B ECHO Project Social Care Managers Forum

Participants

14 Social Care staff participated comprising – 13 Domiciliary Care staff and 1 Residential Manager.

Event Format

Project ECHO is utilised by Social Care Managers as a hub and spoke knowledge sharing network. As part of these monthly meetings, a Being Open and Duty of Candour workshop was undertaken. The multi-point videoconferencing technology was utilised to undertake this meeting.

An **overview** was given of the recommendations of the Hyponatraemia Inquiry relating to duty of candour and Being Open, and overview of the process of the Implementation Programme and the co-production model.

An overview of the recommendations was presented relating to the introduction of a **statutory individual and organisational duty of candour**, with consequent criminal sanctions. Discussions of the workstreams' process, the work done so far and contextualising the introduction in light of existing professional regulation.

A number of case scenarios were raised and questions presented in relation to being open and a duty of candour. These are summarised below.

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

- Absence of blame culture
- Accountability
- Equal playing field to raise concerns
- Focus on learning and improving

- Senior leadership

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

- Blame culture
- Commissioner-provider relationships
- Fear
- Hierarchical system
- Increased pressure on time and resources
- Litigation culture
- Private sector – higher level of candour than statutory sector
- Professional protection of colleagues
- Punitive reactions to being open
- Reliance on process rather than humanity
- Whistleblowing – repercussions of speaking up

3. How could these be overcome?

- Advocacy system to support openness (e.g. speaking out guardian)
- Apology protection
- Champions
- Clearly defined thresholds and guidance
- Just culture
- Leadership and example setting
- Psychological safety
- Structural changes – time and resources

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

- Collusion
- Failure to share information
- Fear of blame and consequences
- Heavy regulation
- Hierarchy
- Lack of leadership
- Lack of professional oversight
- Lack of support from management
- Lack of teamwork
- Loyalty to colleagues and team dynamics
- Organisational culture
- Protecting reputation
- System pressure – finances etc.
- Values of staff members

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

- Appropriate reaction when things go wrong
- Induction designed to embed the duty of candour
- Just culture
- Not perfect
- Promoting openness and honest as values
- Recognising and accepting that mistakes will happen
- Reflective practice
- Sharing learning
- Structures to support candour
- Support from line management
- Supportive regulation

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

- Lack of honesty could be punished by a fine or disciplinary procedures

Future Involvement

7. Ideas for involving Social Care Workers in taking this work forward?

- Baseline assessment tool for candour and openness
- Co-production of guidance
- Pilot exercises to test being open initiatives
- Regular updates on developments
- Sharing learning and good examples

APPENDIX 1.10 Pharmacy Leads views on Duty of Candour and Being Open

SUMMARY of FEEDBACK

Introduction

On Thursday 19th December 2019, a workshop event was held with pharmacy leads across HSC to discuss the duty of candour and being open.

Participants

9 participants comprising - Acting Chief Pharmaceutical Officer, a member of the Department of Health pharmacy team, 3 members of the Pharmacy team from the Health and Social Care Board, and 4 of the 5 pharmacy leads from the Health and Social Care Trusts.

Event Format

An informal approach was undertaken to engage the group. An overview was given of the recommendations of the Hyponatraemia Inquiry relating to duty of candour and being open, and an overview of the process of the Implementation Programme and the co-production model. Participants then worked through the questions set out below, referring to a case study as necessary.

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

- Appetite for challenge
- Appetite for risk/ acceptance of risk/ mistakes happen
- Approachable
- At all levels
- Board Leadership
- Consistent + embedded + livid
- Day + daily
- Empower to be open
- Encouraged for learning
- Just culture - Consultancy
- Leadership - openness valued
- No blame
- Not Governance
- Objective

- Open communication
- Proportionate responses
- Tune and process to be open
- Uniformity in approach
- Value of openness
- willingness to reflect on consequences of action

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

- Culture
- "Delay is not openness"
- "Nobody wins in whistleblowing"
- Absence of context
- Administration recording
- Better managers
- Bigger multinational cultures - How do we influence that?
- Burdensome systems
- Bureaucracy
- Community pharmacists - dependant oh GPs for business
- Confusing system
- Content
- Cumbersome rules
- Defensive culture
- Delays
- Engage users
- Feedback overload
- Flow of challenge
- lack of control
- Lack of insight + need for support
- lack of Leadership
- Media
- OoH - prescribing issues
- Perception of regulation
- Pharmacy - prosecution for errors?
- Pharmacy reporting to a safety net
- Poor communication
- Poor medicine compliance
- Professional rivalry
- Relationships
- System is busy
- Time
- Time and resources

- Understanding completely
- Unrealistic expectations

3. How can these barriers be overcome?

- Better systems for sharing learning
- Better understanding idle for pharmacists
- Better use of data
- Challenge
- consultancy
- Consultants and communication to share learning - local level learning
- Coordinate feedback
- Developing service and support
- Easier process + more explicit
- Economic of scale
- efficient use of learning systems
- Experienced and trained staff
- Family engagement
- Humane
- Job description - openness
- Learning specific to local carers
- manageable processes
- Open and fair processes
- opportunities to learn
- Professional development
- Protect and support staff to be open + to learn - compassionate
- Real time reflection
- Shape media narrative
- SQE programmes - Safely handle
- support staff to learn
- Support to deliver bad news
- Technology to support learning
- Training
- Whole system learning

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

- Professional sanctions achieve none aim + proportionate
- How will organisational offence
- Mistakes

Future Involvement

5. How do we involve the pharmacy sector?

- CH - UC Conference
- CPD
- Facilitate event
- Geography
- Medicines safety - infographic
- Multi-method
- OoH
- Pharmacy forum
- Questionnaire
- Round table discussions
- TB - pharmacy forum

APPENDIX 1.11 GP views on Duty of Candour and Being Open

Introduction

1 event took place on Tuesday 29th September 2020, which invited G.P.'s and Practice staff. This event was previously scheduled for March 2020 but had to be postponed due to Covid-19.

Participants

49 participants attended the on-line event comprising – 42 GP's; 3 Practice Managers; 2 British Medical Association (BMA) staff; 1 GP Medical Advisor (HSCB) and 1 Integrated Care Business Manager (HSCB).

Event Format

The event took place via a virtual platform – Zoom. An **overview** was given of the recommendations of the Hyponatraemia Inquiry relating to duty of candour and Being Open, and an overview of the process of the Implementation Programme and the co-production model.

The work of the **Being Open workstream** was presented and its relationship to a statutory duty of candour. This focused on cultural change within the health service to a more open system and the opportunity to implement these changes quickly compared to the longer timescales associated with the introduction of candour legislation.

An overview of the recommendations was presented relating to the introduction of a **statutory individual and organisational duty of candour, with consequent criminal sanctions**. Discussions of the workstreams' process, the work done so far and contextualising the introduction in light of existing professional regulation.

At the event participants worked in groups to discuss a case scenario and consider questions in relation to being open. These are summarised below.

1. **What does openness look like within your GP Practice?**

- Culture
  - Openness from the beginning
  - Junior staff able to approach senior staff with concerns that something has gone wrong
  - Openness during case discussions and learning from each other
  - All staff in the practice and having good working relationships with all colleagues where issues can be raised and action taken as required
  - Learning v blame culture
  - Having a patient group in place

- Relationship with patient
  - Good communication with patients
  - Explaining options for informed choices – joint decision making
  - Involved from the start
  - Supports the patient journey through primary and secondary care

- Relationship is built on openness
- Actively involve patient when something has gone wrong

- Governance
  - Complaints process/Incident reporting procedures in place and responded to
  - Audit
  - Patient records
  - Less hierarchy in GP Practices

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

- Relationship
  - Able to ask questions and discuss care openly with GP
  - Recognised first point of contact for care
  - GP is approachable
  - Shared decision making – options are provided

- Communication
  - Listen, understand, get advice, be straight and consider what is achievable

3.	**What are the barriers to openness/open culture within GP Practice settings?**

- Protection
  - Legal issues
  - Legislation
  - Patients who have a history of complaints
  - Proportionality of harm
- Culture
  - Blame culture
  - Hostile attitude against GP's
  - Being threatened reduces openness
  - Management structure and systems
  - Openness can be difficult between trainee's and GP
  - Relationships between/within Practices
- Resources
  - Time constraints
  - Waiting lists and operational impact of dealing with harm
  - Size of GP Practice compared to Trusts
  - Complaints are time consuming and emotionally exhausting
- Regulation
  - Significant incident reporting
  - Ombudsman
- Fear
  - Fear of repercussions

- Fear of reprisals
- Fear of livelihood
- Fear of criminal sanction

4.	**How could these be overcome?**

- <u>Communication</u>
  - two-way conversation
  - provide clarity to patients about how things are done
  - willingness to explain what has gone wrong
- Engage
- Help the public understand it's not possible to get things right all of the time
- <u>Culture within the practice</u>
  - Support patient and staff to raise issues and validity of same
- Define openness and what this means for the patient
- Define with constitutes notifiable safety event
- Discuss what goes well and what doesn't go well
- Responsibility for all staff
- Funding
  - Protected time
  - Additional staff
- Guidance and professional opinion supports openness
- Relationships with patients strengthens openness
- Training
- <u>No blame</u>
  - Learning first culture
  - No fault compensation
- Practice meetings

5.	**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?**

- Have conversation with doctor to find out what happened
- Could be significant event at practice level and would present at practice meeting for learning and development
- Case study is example of day to day practice for GP – take risk – case development
- GP and patient discussion
- GP, fellow Practice staff, Practice Manager, patient, trainee's
- Individual level
- Organisational – depending on what services were in place at the time

6.	**What current statutory responsibilities, Professional Standards, Guidance, etc would apply?**

Statutory responsibilities

- Duty of care

Professional Standards/Regulators

- GMC

Others

- Whistleblowing
- Criminal law

7.	**What would your concerns be if a Duty of Candour was in place?**

- Criminal sanction
  - Misunderstanding of what this will mean in practice
- Change in practice
  - Risk adverse practice increases which in turn leads to increased pressure on secondary care services
  - Defensive medicine
  - NI will have a different practice than elsewhere
  - Over investigations which can be demanded by patients
  - Unintended consequences
- Thresholds
  - At what point would candour apply and criminal sanction
  - Who decides at what point you have not been open?
- Relationships
  - Damages relationships with patients
  - Retreat people back into their own practices
  - Unhappy workforce
  - Patients don't always want openness
  - Lack of Trust
- Resources
  - Increased paperwork
  - Increased stress and sick leave
  - Small practices and level of administration support
  - Who is going to monitor/assess if candour is appropriate?
  - Time
  - Level of incidents
- Fear
  - Fear of litigation
  - Fear of criminal sanction
  - Cost of indemnity and insurance costs will increase

- Impact on recruitment for future GP's
- Loss of confidence
- Open disclosure/apology could be taken as an admission of fault
- Openness can move to litigation

8.	**What can be done to overcome these concerns?**

- <u>Recognise difference</u>
  - GP Practices are small
  - Primary care is hugely different from the Health Trusts
  - Can't be a blanket approach
  - Openness is already embedded in GP Practices
- <u>Resources</u>
  - Time for learning and communicating
  - Recognition that GP Practices are small
- <u>Learning rather than blame culture</u>
  - Minimise risks of medical negligence
  - No fear
  - Support is required
  - Introduction of a no blame culture
  - Ensuring openness is not catalyst for instant litigation
  - Continue to build on openness and shared decision making already practiced in GP Practices
- <u>Communication</u>
  - Reduce silo working and enhance communication across NHS
  - Increasing awareness and understanding – where does candour begin and end in comparison to whistleblowing and other standards already in place

9.	**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?**

- Deliberately misleading of information
- Concealing evidence
- Needs to be clearly defined so that patients understand
- If Doctor wilfully practices without due regard to care of their patient
- Intent to do harm
- Criminal sanction identified as barrier
- Culture to be changed at all levels to ensure people are willing to speak up when things go wrong
- Sanctions are already in place via GMC, independent body, and other criminal/legal processes

APPENDIX 1.12 Professional Bodies on Duty of Candour and Being Open

Introduction

On 5th November 2020, a meeting was held with Professional Bodies in Northern Ireland to discuss the duty of candour and being open.

Participants

21 participants comprising – Royal College of Psychiatrists NI, Royal College of Nursing, British Dental Association, Royal College of Occupational Therapists, Royal College of GPs, Royal College of Paediatrics and Child Health, Royal College of Midwives, Professional Association for Social Work and Social Workers, College of Podiatry, MDDUS, MDU, Chartered Society of Physiotherapists, Society and College of Radiographers and the BMA.

Event Format

An overview was given of the recommendations of the Hyponatraemia Inquiry relating to duty of candour and being open, and an overview of the process of the Implementation Programme and the co-production model. Participants then discussed the programme of work, which was captured as follows:

- How may referrals to the GMC?
- What attempt has been made to understand the fear?
- There is a currency of truth – worried about people being the sacrificial lamb
- Criminal sanctions are ineffective in prevention – punishment doesn't change behaviour
- Following an adverse incident there is a conflict between organisations and individuals, and their legal teams, and it is easier to prosecute individuals which acts against the open and learning culture
- Accountability should be left to professional regulation
- Need to be aware of the subtleties of general practice, dentistry and pharmacy and the issue of small practices where someone could be the organisation AND the individual
- Already significant pressure recruiting and retaining medical professionals – people will go elsewhere, particularly when they can go a couple of miles to get across the border.
- How quickly will case law kick in?
- Will the duty be applied retrospectively?
- While it is not about criminalising mistakes, in places like the coroner's court it becomes adversarial and people are hung out to dry.
- Will the recommendations be discussed with O'Hara again to determine his intent behind them?
- Why are we doing this in isolation from other countries? Some other countries are looking at what is happening here and starting to ask if they should follow suit.
- Have we learnt from the experience in England etc?
- Need to consider social work perspective and the inclusion of social care works with very little professional representation
- Dentistry is often carried out in very small practices which means it becomes a double whammy of organisational and individual which leaves them very vulnerable

- Interface between primary and secondary care needs considered – so that Trusts don't shift blame onto primary care
- Although there can be pressure in team environments to be loyal to the team, the organisational duty should be sufficient
- There are other safeguards that could be used, such as extending regulation to non-medical managers
- Need a strong cultural change that includes the public
- A no blame culture is important – how do you address the barriers to achieve cultural change?

Section 2 APPENDICES WORD CLOUDS from Involvement Events

APPENDIX 2.1 HSC staff views - What does an open organisation look like for staff?

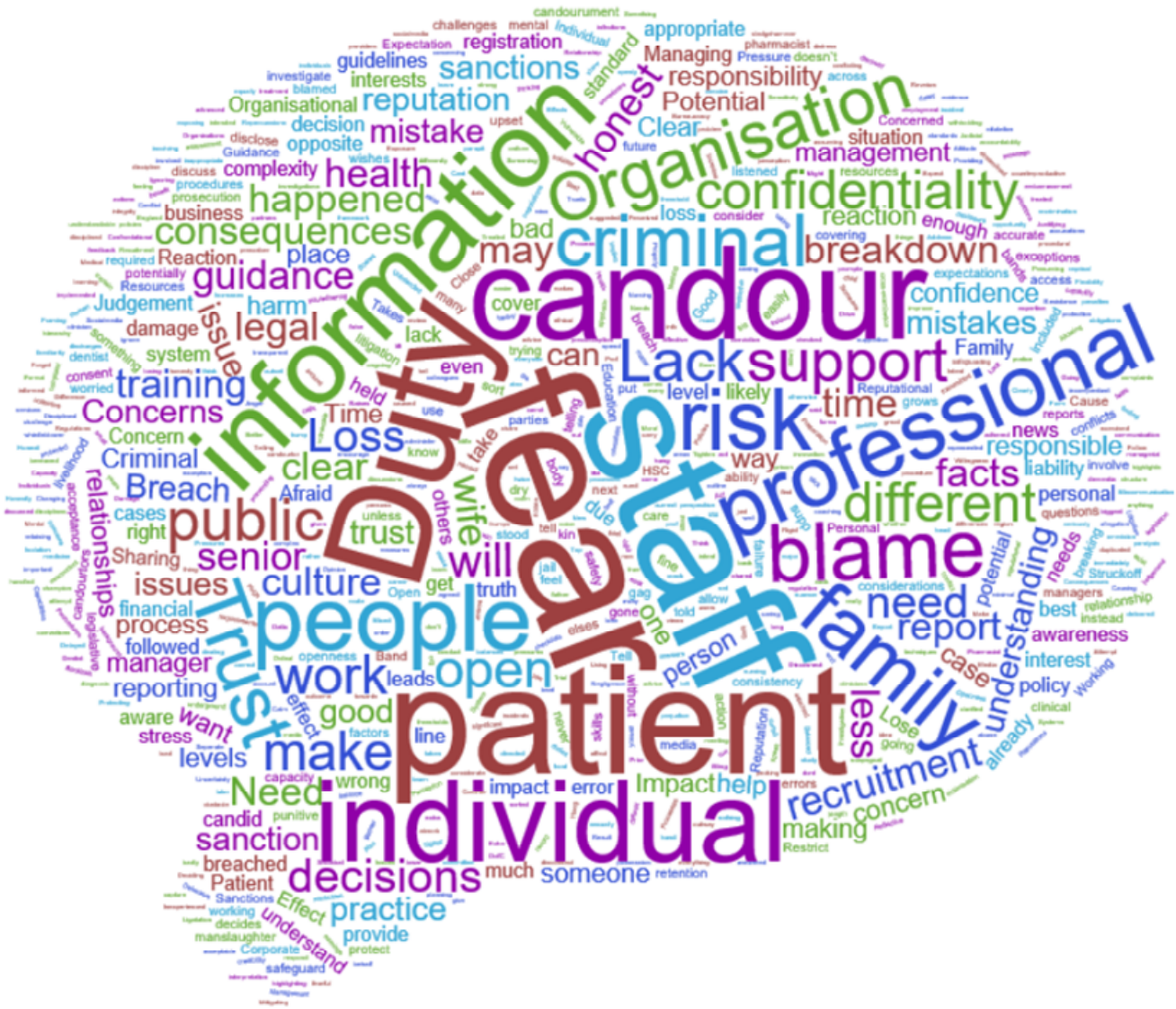
APPENDIX 2.2 HSC staff views - What does and open organisation look like from a patient/carer perspective?

APPENDIX 2.3 HSC staff views - What are the barriers to an open culture?

APPENDIX 2.4 HSC staff views - How could we overcome the barriers?

APPENDIX 2.5 HSC staff views - What statutory responsibilities, Prof standards, guidance etc can assist with the Duty of Candour?

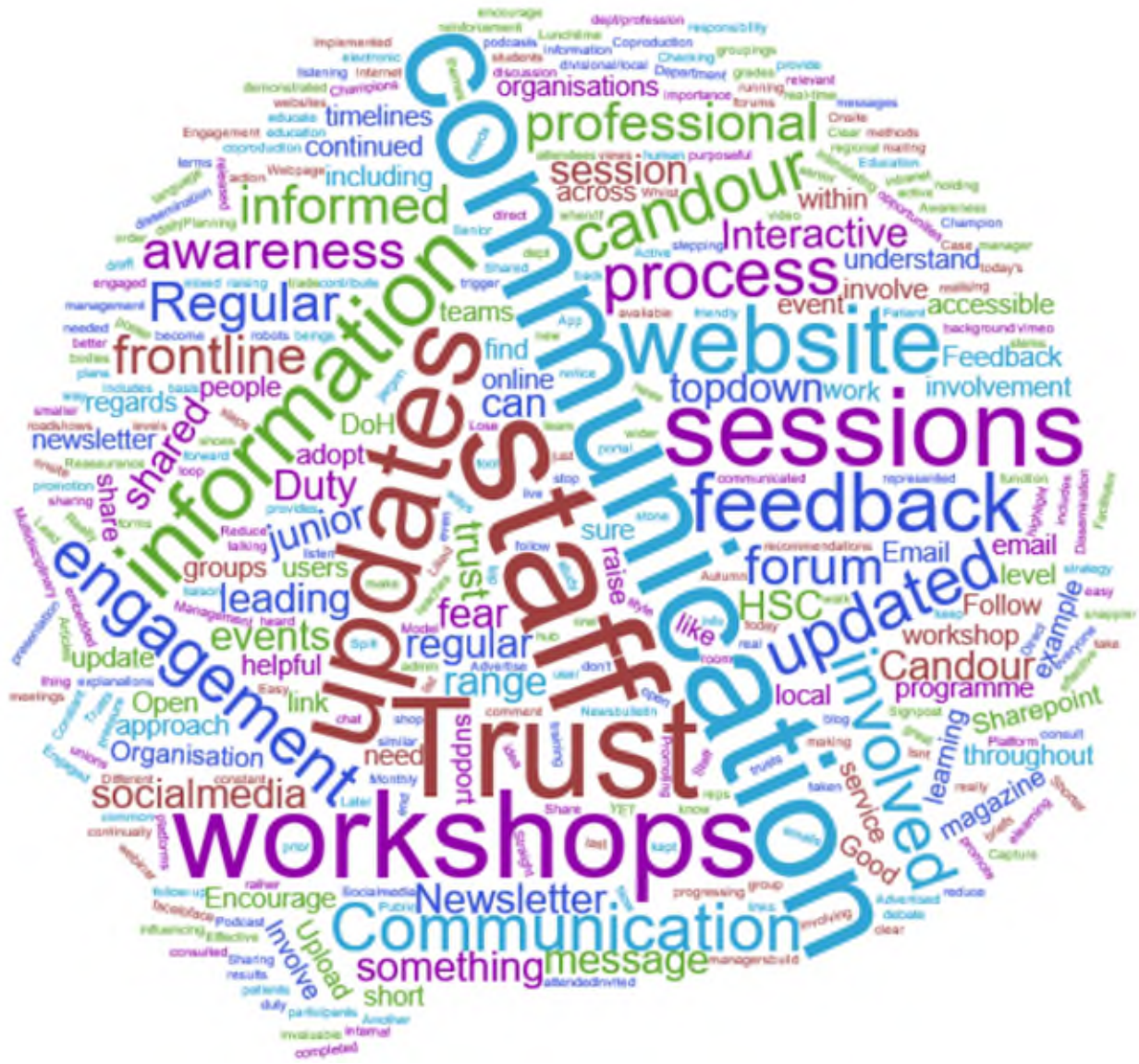
APPENDIX 2.6 HSC staff views - Concerns or potential barriers to a Duty of Candour?



APPENDIX 2.7 HSC staff views - Ways to overcome barriers to a Duty of Candour

APPENDIX 2.8 HSC staff views - Views on criminal sanctions to breaches to a Duty of Candour

APPENDIX 2.9 HSC staff views - Big idea to keep people involved

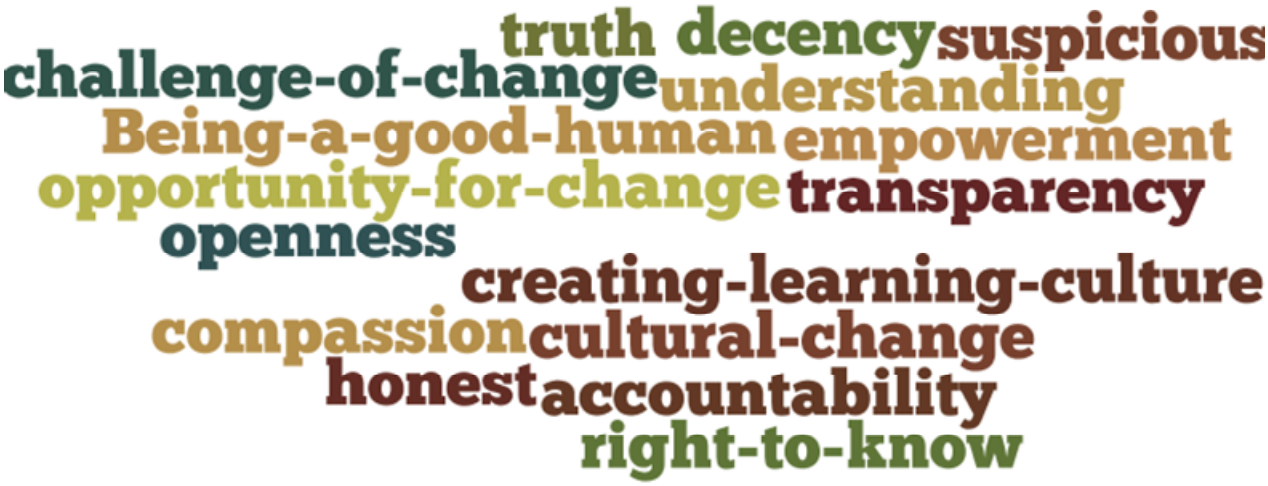


APPENDIX 2.10 Third Sector views on Being open and Duty of Candour

NICVA – What word or words come into your mind when you hear 'Being Open' and 'Duty of Candour[2]

June - Pre-workshop

June - Post workshop



[2] Note – the NICVA event word clouds only capture the words submitted and do not reflect the frequency of use.

September - Pre-workshop

September - Post workshop

Section 3 APPENDICES EVENT Supporting information

APPENDIX 3.1 Case study examples –Involvement events

PCC Membership event

1 A patient in a general medical ward had a cardiac arrest at 7pm. The resuscitation team arrived within 5 minutes and worked with the patient for 30 minutes before concluding that the patient was not going to recover and declared confirmation of death. Looking back at the condition of the patient before this happened, there were signs of deterioration that had not been acted on. A blood result from that morning had not been reviewed and the previous set of vital signs recordings indicated some worrying results that had not been escalated to medical staff[3].

2 A patient in a general medical ward had a cardiac arrest at 7pm. The resuscitation team arrived within 5 minutes and worked with the patient for 30 minutes before concluding that the patient was not going to recover and declared confirmation of death. It was very surprising that this patient arrested as their clinical indicators leading up to this were all good. It was concluded that the sudden nature of this event could not have been avoided[1].

3 A concerned neighbour has called Social Services to report suspected child neglect. The parents receive a visit from Social Services to investigate the claim. The parents have asked for the details of the concern and who reported it[4].

4 You go into your dental surgery for a routine appointment. The dental nurse checks your name and, when she realises who you are, offers her condolences for the loss of your brother who has recently died. As there has been a family falling out, you were not aware of his death and are very upset about hearing about his death in this way. The dental nurse explains that your brother also attended the same surgery and she was not aware of the family dispute[5].

5 An 85 year old man is in hospital and test results show he has cancer. Prior to his admission, he was living on his own independently and was fully able to make decisions on his own. The family have told staff that they do not want him told that he has cancer, as they believe he will not be able to cope with the diagnosis[3].

6 A confused elderly patient was supposed to have 1:1 supervision and observation on a medical ward. The patient was left unsupervised for a period of time whilst the shift change

[3] Healthcare Improvement Scotland, Duty of Candour Portfolio of Examples V3.0, available at http://www.knowledge.scot.nhs.uk/adverse-events/duty-of-candour.aspx
[4] Department of Health, Safety, Quality and Standards Directorate
[5] General Dental Council

was occurring and the patient fell out of bed, sustaining a fractured neck of femur for which she required surgery[6].

HSC Trust events

1[7] A patient who is a heavy smoker with a persistent cough is noted to have a suspicious lesion on a chest x-ray. The GP messages the practice reception to arrange an urgent appointment with the patient, although there is no answer on the patient's home telephone as he is on holiday. The message to follow up is missed. Two months later the patient presents with shortness of breath and haemoptysis*. He is admitted to hospital and is diagnosed with lung cancer. His chances of survival were believed to be significantly reduced due to the delay[2].

***Haemoptysis** is the act of coughing up blood or blood-stained mucus from the bronchi, larynx, trachea, or lungs. This can occur with lung cancer, infections such as tuberculosis, bronchitis, or pneumonia, and certain cardiovascular conditions.

2 A 26 year old man, who is believed to be fit and healthy, is scheduled for what is understood to be a low risk surgical procedure. He has the preoperative assessment and 'workup', including blood sampling. The operation proceeds and, unexpectedly, he dies of sudden cardiac arrest. Upon review, it transpires that the preoperative blood results were not reviewed prior to the procedure. They indicated an undiagnosed degree of chronic renal failure, including a degree of hyperkalaemia. As a consequence, the administration of a muscle relaxant as part of anaesthesia triggered a sudden cardiac arrest. At a meeting with the Director of Legal Services and senior management in the Trust as part of preparations for a meeting with the patient's family, it is suggested that the failure to review pre-operative blood results should not be mentioned to the family[3].

3 An 85 year old man is in hospital and test results show he has cancer. Prior to his admission he was living on his own independently and was fully able to make decisions on his own. The family have told staff that they do not want him told that he has cancer, as they believe he will not be able to cope with the diagnosis[3].

4 An 80-year old man is admitted to hospital and is suffering from a stroke, signs of dementia and loss of co-ordination. The origin of these conditions is that he is suffering from syphilis, which he contracted 15 years before. This has gone untreated as he did not seek treatment out of embarrassment. The syphilis has progressed to third or later stage (tertiary) syphilis. Whilst it can be treated, it is not clear if it is possible to repair the damage that has been done. His wife seems unaware that he has syphilis and wants to know what the diagnosis is, what the treatment plan is and what the prognosis is[3].

5 Patient attends dental surgery for routine replacement of a failed restoration which was picked up from bitewing radiographs* taken at the routine exam, three weeks previously.

[6] Department of Health, NMAHP Directorate

[7] Case study withdrawn after 1st workshop session due to subject area being focused on Primary Care rather than HSC setting.

Consent is obtained for the treatment after reviewing the plan on the computer. Local anaesthesia is administered, the tooth is prepared, and the dentist is surprised that there is no decay present in the tooth. The dentist completes the restoration and at the end of the appointment reviews the radiograph that he had taken at the previous appointment. The dentist realises that the equivalent tooth on the other side has been treated in error. The error is compounded by the realisation that the tooth that was charted requiring a restoration was an unrestored, decay free tooth and that the tooth requiring treatment on the other side, had a previous restoration[2].

*A dental x-ray film with a central projection on which the teeth can close, holding it in position for the radiographic examination of several upper and lower teeth simultaneously.

6 A pharmacist identifies that a doctor has made a number of potentially serious prescribing errors. However, no harm was caused as the errors were detected before the medication was dispensed or administered, but they had the potential to cause serious harm. The pharmacist redispenses the correct medication but doesn't apologise or provide any explanation to the patients as to why this may have occurred. The pharmacist informs the doctor but does not 'formally' raise their concerns about this practitioner as they acknowledge that the doctor is working under stressful conditions, and is likely to be overtired[8].

7 Debbie is a very articulate 15 1/2 year old, an only child who confides in a teacher that she may have been inappropriately touched by her father in the past. She is dealing with it and does want to talk about it to someone. She is adamant that if anyone were to approach her parents, she would deny completely that anything has happened. The school with her consent refer the matter to social services. A decision is made in conjunction with the police that social services engage with her to talk through what has happened, assess her ability to keep herself safe, and to decide on any risks her father poses. The Social Workers are guided by the fact that she is Gillick competent*, as well as their regulator's standards around Service User choice and confidentiality. The decision is also made that if Debbie reveals at any point that the abuse has restarted, that social services will take action under the joint protocol**. It is agreed that social services will not share this information with Debbie lest it discourages her from engaging with social services to get help[3].

*Gillick competent is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

**Joint protocol for joint investigation by social workers and police officers of alleged and suspected cases of child abuse.

[8] Department of Health, Pharmaceutical Directorate

NI Community Voluntary Action (NICVA) event

1 A patient was being cared for in a hospice who was nearing the end of their life. A risk assessment was carried out that identified a risk of developing pressure ulcers so measures were to be put in place (pressure relieving mattress and cushion with 2 hourly repositioning). After discussing pressure relieving measures with colleagues and the patient's family members, the decision was made to consider the patient's comfort at that time rather than repositioning. Consequently, the patient developed a grade 3 pressure ulcer[2].

2 A new member of staff on induction was shadowing another care worker delivering care to a person who needed to be hoisted. Two trained members of staff were required to operate the hoist safely and the new member of staff had not yet been trained in moving and handling. The new care worker was asked to assist with the manoeuvre and did not attach one of the loops of the sling to the hoist properly. As a result, during the manoeuvre, the person slid out of the sling and onto the floor. The person sustained a broken hip requiring emergency surgery[2].

3 An Occupational Therapist (OT) completed an assessment with a care home resident whose mobility was deteriorating. The OT advised that grab rails were needed in a person's bathroom before it was safe for them to use the bath and that in the meantime staff should assist the person to have a strip wash each morning. The manager failed to update the person's care plan or inform the care staff of this change, so staff supported the person to take a bath the following morning as usual. The person slipped when getting out of the bath and sustained a broken arm. The arm was put in a plaster cast and the person needed full assistance for all aspects of their care for 6 weeks until the cast was removed. The person made a full recovery[2].

4 An 80 year old man with dementia, including a history of recurrent falls as well as previous stroke and heart disease, is resident in a nursing home. At 2am he fell and sustained a head injury. Nursing staff contacted the doctor on call, who advised that he be observed and monitored. Staff observed the patient until he fell asleep at 5am. Staff next attended the patient when he woke the following morning at 9am, and became concerned about the extent of his injury, which had increased in severity since he was last observed. Based on further advice from the doctor on call, nursing staff requested an ambulance, which arrived at 1pm to take the patient to hospital. A subsequent CT scan at the hospital revealed a small traumatic subarachnoid haemorrhage, but neurological observations were normal[3].

5 A young adult with a learning disability who lives in supported accommodation was expecting a visit from her usual key worker. The key worker, who was a learning disabilities nurse, had forgotten to inform his client that he would be on annual leave and someone different would visit instead. In addition, due to an overlap of annual leave he did not have time to explain the nature of the client's behaviour to the replacement nurse and had not recorded in the notes that certain rituals needed to be observed to prevent the client from becoming anxious and leading to possible self-harm. As a result the client became very distressed when the replacement nurse visited and the nurse had difficulty in calming her down. Eventually the client appeared calm and the nurse left. Later on, the client could not

cope with the distress caused and cut her forearms with a razor. She called her parents and they took her to hospital where she was treated for superficial cuts to her forearms and sent home in the care of her parents[2].

Independent Health and Care Providers event

1. A patient was being cared for in a hospice who was nearing the end of their life. A risk assessment was carried out that identified a risk of developing pressure ulcers so measures were to be put in place (pressure relieving mattress and cushion with 2 hourly repositioning). After discussing pressure relieving measures with colleagues and the patient's family members, the decision was made to consider the patient's comfort at that time rather than repositioning. Consequently, the patient developed a grade 3 pressure ulcer*.

   *this is when the ulcer has usually started to open. The skin beneath is more visible and red. There may be a smell emanating from the ulcer. It now looks unpleasant.

2. A new member of staff on induction was shadowing another care worker, who was delivering care to a person who needed to be hoisted. Two trained members of staff were required to operate the hoist safely and the new member of staff had not yet been trained in moving and handling. The new care worker was asked to assist with the manoeuvre and did not attach one of the loops of the sling to the hoist properly. As a result, during the manoeuvre, the person slid out of the sling and onto the floor. The person sustained a broken hip requiring emergency surgery.

3. An Occupational Therapist (OT) completed an assessment with a care home resident whose mobility was deteriorating. The OT advised that grab rails were needed in the person's bathroom before it was safe for them to use the bath and that in the meantime staff should assist the person to have a strip wash each morning. The manager failed to update the person's care plan or inform the care staff of this change, so staff supported the person to take a bath the following morning as usual. The person slipped when getting out of the bath and sustained a broken arm. The arm was put in a plaster cast and the person needed full assistance for all aspects of their care for 6 weeks until the cast was removed. The person made a full recovery.

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** A subarachnoid haemorrhage is an uncommon type of stroke caused by bleeding on the surface of the brain. It's a very serious condition and can be fatal.

5. A young adult with a learning disability who lives in supported accommodation was expecting a visit from her usual key worker. The key worker, who was a learning disabilities nurse, had forgotten to inform his client that he would be on annual leave and someone different would visit instead. In addition, due to an overlap of annual leave he did not have time to explain the nature of the client's behaviour to the replacement nurse and had not recorded in the notes that certain rituals needed to be observed to prevent the client from becoming anxious and leading to possible self-harm. As a result the client became very distressed when the replacement nurse visited and the nurse had difficulty in calming her down. Eventually the client appeared calm and the nurse left. Later on, the client could not cope with the distress caused and cut her forearms with a razor. She called her parents and they took her to hospital where she was treated for superficial cuts to her forearms and sent home in the care of her parents.

Private Healthcare Providers event

1. A 37 year-old man (Mr K) was scheduled for right knee arthroscopy after a period of pain and difficulty moving; English is not his first language. Prior to the procedure Mr K was seen by the orthopaedic consultant and the consent form for arthroscopy of his right knee was completed.

   On the day of admission Mr K's right knee was marked as part of the pre-operative preparation. In theatre the procedure was carried out on the left leg until an operating department orderly noticed that the procedure was been carried out on the wrong knee and brought it to the surgeons attention. The procedure on the left knee was stopped and the right knee arthroscopy was carried out as required[9].

Service user and carer event

1. An elderly patient is scheduled to have hip replacement surgery. The surgery is completed. The patient is reviewed following the surgery. Their x-ray is normal and they do not complain of any unusual pain. On reviewing the patient's notes, the Consultant Surgeon realises that a piece of the artificial hip which was inserted is the wrong size. Medical research is not clear about whether this can cause long-term harm to the patient. In some cases an error like this can lead to further complications, and in others the error will not lead to any harm being caused. However, the only option to guarantee a good outcome is to perform further surgery and change the incorrect piece of the replacement hip.

[9] Department of Health

Dental sector event

1. A patient attends for a booked filling and the dentist is running 20 minutes late. When the patient goes in, the dentist seems a bit distracted and rushed. The Dentist apologises for running late, quickly checks the notes and asks the nurse to pass the local anaesthetic to numb the patient's mouth. The Dentist begins by putting a gel on the gum on the right hand side. The patient thought that this was seems strange as the filling was due to be on the left, but assumes that the Dentist knows what they are doing. However, the Dentist then injects the right hand side and, before the patient's mouth goes numb, they ask the Dentist whether they will be numbing the left gum as well. The dentist is surprised and turns to check the notes on the computer screen. It then becomes apparent that they have numbed up the wrong side, because in their haste they have called up the notes for another patient with the same surname and first initial[10].

2. A patient has a nagging toothache at the back of their mouth, has recently moved to a new area, and is attending a new dentist for the first time. The Dentist carries out a check-up and x-rays are taken. Studying the x-ray, the Dentist recommends that the patient needs a deep filling on their back tooth, which can be done there and then. They discuss the different options, and agree to have a mercury filling. As part of the discussion, the dentist warns the patient that because it is a deep filling, the discomfort could persist for a couple of days. Four days later, the patient is still in pain and it is not improving. The patient goes back to the practice and the dentist, on looking again at the patient's notes, realises that they have mistakenly filled the wrong tooth[10].

3. A child is referred by their dentist to a Specialist Orthodontic Practice for an opinion and treatment of crowding. The referral practice write back to the dentist with a treatment plan which includes extraction of all four second premolars and asks that the dentist does this before the planned date of the orthodontic appliance fitting. The child is booked in for the extractions and consent is obtained for the treatment to be carried out over two visits. At this first visit, the dentist extracts the first molars on one side, and while the patient is recovering, he reads the letter and immediately realises that the wrong teeth have been extracted[3].

4. A patient attends for a routine exam, the dentist notes an ulcer on the side of the tongue which has no obvious cause. The dentist discussed the ulcer, which the patient is unaware of and a review of medical and social history reveals no significant risk factors. The dentist advises the patient to make a review appointment in 1 week and that if the ulcer is still present or has increased in size, this will be followed up with an urgent referral to the local maxillo-facial department. The patient makes this review appointment but fails to attend. The dentist, during his busy day, misses this, and reception staff also fail to note this or contact the patient to rearrange the appointment. Subsequently, the patient is referred by their GP after attending with difficulty swallowing. The diagnosis of squamous cell carcinoma is made by the maxillo-facial team and treatment commences. The patient remembers that this had been discussed some months previously at a routine dental appointment and the maxillo-facial team asks why the patient hadn't been referred then[3].

[10] General Dental Council

5. A patient attends for root canal treatment of an upper premolar. Consent is obtained and at the visit, the root canal is located and cleaned after rubber dam has been placed. The root canal is then irrigated with Sodium Hypochlorite and at this point the patient reports significant discomfort. The dentist immediately irrigates the root with saline and dresses the tooth. The dentist gives the patient a quick explanation of what has happened, namely that the irrigant has extruded beyond the end of the root and caused an acute tissue reaction. Further immediate treatment of pain relief, cold compress over the affected area and antibiotics is given. The patient is distressed and asks why this risk hadn't been explained. The dentist apologises and says that it is such a rare occurrence that it had been omitted from his pre-treatment explanation. An onward immediate referral to secondary care was made[11].

Social Care Managers event

1 In an adolescent unit there was a serious incident of self- harm with a young person in which emergency services had to attend. A social worker was managing this incident along with other serious incidents in the young person's facility. The social worker had to leave the young person alone while seeing to other young people. The young person was admitted to hospital.

Following the incident, an incident report was completed and given to a senior member of staff for review and sign off. The senior member of staff was concerned that the lack of surveillance and care for the young person would reflect badly on the organisation and potentially compromise current and future funding from the relevant Trust. The senior member of staff altered the report regarding the fact that the vulnerable young person had been left alone and at risk of harm while the member of staff on duty dealt with other calls within the understaffed and overstretched facility.

2 A senior social care worker with responsibility for the administration of medication incorrectly admitted the wrong dose of medication to a person over a number of days. On realising that the dosage and frequency was wrong she altered the records, forged signatures and deliberately poured coffee over the report / log card to cover up her actions.

3 An older person in a care home fell and seriously injured herself. A junior member of staff came forward as a witness for the senior member of staff following a complaint from the family and person in care. The junior member of staff colluded with the senior member of staff claiming that the woman had fallen but required no medical assistance during their shift. The older person was settled in bed and not admitted to hospital. Staff on the next shift were not made aware of any incident and when attending to the older person realised that she required medical assistance and called for an ambulance. The older person had suffered a fracture to the neck of the left femur and wrist and injured her hip.

[11] Care Quality Commission

GP Practice event

A young man falls over whilst playing badminton and presents to his GP the next day with a swollen and painful foot and ankle. His GP decides not to order an x-ray and sends him home with advice to rest, ice, compress and elevate the leg. He tells the man he can weight-bear fully.

Over the following week, the pain and swelling does not improve and the man re-presents at the GP surgery and sees a different doctor who sends him for an x-ray. He is found to have a fracture of the base of 5th metatarsal which should have been managed in a plaster cast and non-weight bearing.

Due to this mismanagement, the patient develops a non-union over the following 6 weeks which causes him ongoing pain and eventually requires surgical intervention in hospital[12].

[12] Care Quality Commission

APPENDIX 3.2 Summary of individuals involved

PCC Membership events:

- Belfast 22 May 2019 (107 attendees)
- L'Derry June 2019 (25 attendees)

HSC staff events

- WHSCT - Waterfoot Hotel 45 attendees
- NHSCT - Dunsilly Arms Hotel 80 attendees
- SEHSCT - The Pavilion 88 attendees
- SHSCT - Craigavon Civic Centre 82 attendees
- WHSCT - South West Acute Hospital 39 attendees
- BHSCT - Grosvenor House 67 attendees

Participants:

401 staff attended events comprising - 148 nursing; 65 admin & clerical; 43 medical/ dental; 16 multi-professional; 31 social services; 25 scientific/ technical; 15 support/ user experience; 8 ambulance; 17 senior executives and the remaining 33 participants unspecified.

Independent Health and Social Care sector event

27 participants attended the event comprising – 1 owner; 2 Chief Executives; 5 Directors; 2 Heads of Service; 15 Managers; 1 Nurse and 1 Graduate.

Private Healthcare Provider's event

4 participants attended the event comprising – 1 Consultant; 2 Managers and 1 Nurse.

Dental Sector event

44 participants attended the event comprising – 36 Dentists; 4 Dental Care Professionals; 1 Dental Practice staff; 1 Dental Nurse and 2 participants unspecified.

Service users and carers event

25 participants

Social Care Managers events

200 participants

Pharmacy Leads event

9 participants

G.P. Practice event

49 participants

Professional Bodies event

21 participants

NI Community Voluntary Action (NICVA) event

Participants:

27 June 2019

Name[13]	Organisation
Colin Harper	Camphill Communities Trust
Seamus McAleavey	NICVA
Chris Eisenstadt	Parenting N I
David Babington	Action Mental Health
Deirdre Quinn	Women's Resource and Development Agency
Lynda Gould	Action on Hearing Loss
Pat Sheehan MLA	Sinn Féin
Nigel McKinney	County Down Rural Community Network
Mandy Cowden	Creative Local Action Response and Engagement
Joanne Corcoran	Positive Futures
Kathleen Toner	The Fostering Network
Denise Cranston	Business in the Community
Pauline Herbison	Royal Society for the Prevention of Accidents
Phil Alexander	Cancer Fund for Children
Jan Wright	Family Fund Trust
Margaret Henry	Council for the Homeless
Jenny Potter	NOW Group
Paul Curran	Boys and Girls Clubs
Charlie Fisher	Development Trusts NI
Rachel Long	NIACRO
Peter McBride	'Being Open' Subgroup Chair
David Daly	WAVE
Seana Talbot	'Being Open' Subgroup Vice-Chair
Julie Aiken	Samaritans
Emma Weaver	Rosewood Community Wellbeing Service
Jenny Irvine	ARC Healthy Living Centre
Lindsay Wallace	Contact A Family
Linda Armitage	EBCDA
Michael Steven	Trans Pride Northern Ireland
Jill Huston	The Hummingbird Project
Bob Stronge	Advice NI
Anne-Marie McClure	Start360
Alex Bunting	Addiction NI
John McCormick	Versus Arthritis
Janet Schofield	Compass Advocacy Network

[13] *Attendees who were late attending may not be recorded.*

Annie Armstrong	Colin Neighbourhood Partnership
Johnathan McCartney	Zest – Healing The Hurt
Mary Friel	British Red Cross
Kate Laverty	Community Evaluation
Claire Curran	Survivors of Suicide Support Group
Anne McCann	Eating Disorders Association
Breige O'Kane	Lymphoedema Support NI
Fiona McAnespie	Radius Housing
Mairead O'Connor	The Wheel
Heather Weir	NI Hospice
Phyllis Graham	Association of Talking Newspapers
Emma O'Neill	Centre for Independent Living
Philip Mynes	NICVA
Geoff Nuttall	NICVA
Paddy Kelly	Children's Law Centre
Duane Farrell	Relate NI
Ellen Finlay	Children in Northern Ireland
Hilary Irwin	Radius Housing
Pearl Coulter	Mindwise
Ellen Nixon	Mid and East Antrim Agewell Partnership
Orla Watt	Parent Action
Laura Bradley	Shine
Clare Watson	Epilepsy Action

30 September 2019

Name	**Organisation**
Fergal Bradley	Department of Health, IHRD Programme Manager
Peter McBride	'Being Open' Sub-Group Chair
Quintin Oliver	'Duty of Candour' Workstream Chair
Claire Fordyce	Public Health Agency
Alan Weir	Department of Health
Geoff Nuttall	NICVA
Siobhan McAlister	NICVA
Bernadine McCrory	Alzheimer's Society
Lisa McGrath	Mencap
Jamie Wallace	Depaul
Orla Conway	CAUSE
Jennifer Hunter	Strabane New Bridge Advocates
Maura McMenamin	Ulster GAA
Mary Tennyson	G-Old Community Partnership Surestart Project
Maura Twohig	Tara Centre