Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

DUTY OF CANDOUR & BEING OPEN – DRAFT POLICY PROPOSALS FOR CONSULTATION

Summary

In January 2018, Justice John O'Hara published his report on the Inquiry into Hyponatraemia-Related Deaths (IHRD). His first recommendation was that a statutory Duty of Candour should be enacted in Northern Ireland and that it should apply to Healthcare Organisations and everyone working for them. Justice O'Hara also recommended that criminal liability should attach to breach of this duty and to obstruction of another in the performance of this duty. He made further recommendations about the guidance, support and protection that should be provided for staff in order to create a more open culture.

In response, the Department of Health (DoH) established an Implementation Programme to take forward the recommendations arising from the Inquiry and the Duty of Candour Workstream, and its Being Open subgroup, have been responsible for developing the proposal options to address the recommendations on candour.

Through a co-production process, the Workstream and Subgroup have developed policy options for the statutory Duty of Candour and the policy framework for Being Open guidance, taking account of: research commissioned and evidence submitted; feedback from staff and service users; and input from other key stakeholders.

The DoH is now seeking your views on the following proposals developed by the Workstream and Subgroup:

a. Policy options for the statutory organisational Duty of Candour; and

b. Policy options for the statutory individual Duty of Candour; and

c. The policy framework for Being Open guidance.

A detailed summary of these proposals is available here on the DoH website.

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Ways to respond

The consultation opened on 12 April 2021 and will close on 2 August 2021. Stakeholders can respond by completing this questionnaire, or by submitting their own written response, to the policy proposals to:

E-mail: IHR.implementation@health-ni.gov.uk D

Written: IHRD Implementation

Department of Health

Room D1

Castle Buildings

Stormont Estate, BELFAST

BT4 3SQ

In addition, an online questionnaire is available on the Citizen Space website here, which allows stakeholders the opportunity to respond to the consultation questions online.

If, for any reason, you are unable to access the electronic versions of the documents you can request a paper copy by e-mailing IHRD.implementation@health-ni.gov.uk or by writing to the address below. The consultation documents, including the questionnaire, may also be requested in an alternative format by also contacting this address.

BEFORE RESPONDING TO THIS CONSULTATION I WISH TO RAISE A MATTER OF POSSIBLE INCONSISTENCY AND AMBIGUITY

Reading the Consultation document it is clear that there is a very heavy imbalance towards the 'Health' side of Health & Social Care. *(not unreasonable or unexpected given the origins of IHRD)*

See 2.4, second bullet point, with references to the quality of healthcare being dependent on clinical and non-clinical services – a fair point as we are supposed to have an integrated service and *Duty of Candour & Being Open* is intended to be enacted HSC-wide.

2.6 Recommendations refers only to 'patients' at 1(i), 1(ii), 1(iii), 1(vi), 1(vii).

I accept that there are references to 'Service Users' in the Foreword, 5.9 & elsewhere. That however only serves to highlight inconsistency & ambiguity of language.

The term 'patient' has clear medical/clinical connotations.

When it comes to Social Care the usual reference is to 'service users'.

Neither term is defined in the Glossary.

These two groups have some commonality of need, part of a continuum, but equally significant differences of approach

Patients receive treatment for diagnosed conditions, usually episodic, time bound with clear prospects of discharge with defined treatments, drug & surgical procedures etc

Services Users usually need personalised long-term care & support, often for age-related or degenerative conditions with little or no prospect of discharge.

There are different methods of diagnosis, assessment, different approaches to information gathering & analysis, recording etc.

In July 2014 Kingston University's Institute for Child- Centered Interprofessional Practice (ICCIP) published a Research report for Dept of Education entitled 'A Study to Investigate the Barriers to Learning from

Serious Case Reviews and Identify ways of Overcoming These Barriers' by Rawlings, Paliokosta et al

I have included a number of references to this report in my response as it looks at matters from a social work/social care perspective and, from my perspective, offers a degree of 'balance'.

[redacted]

Terminology (paragraphs 2.25 – 2.27)

1. Do you agree with the terminology and definitions adopted by the Workstream in respect of "openness" and "candour"? If yes, please provide any additional information and / or insights.

Yes – subject to comments above.

There is considerable merit in adopting an existing definition as specified by Sir Robert Francis - his work is going to play substantial role in defining NHS/HSC policy now and in the future.

Best to resist the temptation to reinvent the wheel for a number of reasons: -.

The nature of UK medical, nursing & Allied Healthcare Professionals training across the UK, freedoms to register & practice, common core curriculum although universities/colleges may have their own styles, strengths & weaknesses etc

The role of various Royal Colleges and other Professionals Bodies in registration/licensing & fitness to practice & their various Codes of Conduct/Practice

Commonality of definition will lead to commonality of interpretation & implementation

Although statute law may differ across the four UK countries, many of the basic principles of *Candour & Being Open* will not & in the worst case the role of the UK Supreme Court offers probability of common law case law being applied consistently including 'read across' from other analogous civil & criminal law such as Data Protection/FOI/Financial Services & Markets etc.

The Kingston University ICCIP report for Dept of Education references many of the same issues as IHRD as regards reliance on strengthening 'ethical duty' as a way of achieving change. A salient point identified in this report is 'who learns?' from the recommendations produced by many inquiries over the years. Their answer was, broadly, senior managers and administrators who would write or rewrite guidelines etc. Only problem was that channels of communication were not effective enough at ensuring that the message got to the folks on the front-line delivering service.

Creating Statutory Duties at both organisational & individual level will only work if the communications channels available are robust enough the get the message through.

2. If not, do you suggest a preferred terminology that should be used to describe this policy and the statutory duty? Please provide evidence to support any alternative proposal.

No suggestions

Statutory Organisational Duty of Candour (Section 3)

Scope (paragraph 3.8 – 3.9)

3. Do you agree with the proposed scope of the statutory organisational Duty of Candour? If yes, please provide any additional information.

On reflection, No. Scope cannot be limited to 'every healthcare organisation'. if that is defined by the list in 3.8 HSC service provision involves a wide range of public, private, independent, community and voluntary organisations all of which need to be captured within the scope on the basis that they may be caught by the **'obstruction'** concept:-. Public-Private Finance or Initiatives, Special Purpose Vehicles, facilities management, contracting-out of services, separation of ownership/control of assets from management of operations, Staffing Agencies, Personal Service Companies and self-employment. Presumably the organisational duty which extends to the Dept also extends by implication to the Minister as head of the Dept & thus responsible/accountable for policy formulation & implementation. Page 82 5.32 Footnote 44 I assume that if the Patient Advocacy Service be established it will itself be subject to the Duty of Candour & Being Open & that obstruction of its work would logically become an offence under both organisational & individual statutory responsibilities.

4. If not, do you have a preferred approach for the scope of the statutory organisational Duty of Candour? For example, should the scope be limited to regulated organisations that directly provide health and social care services? Please provide evidence to support any alternative proposal.

I do suspect that the scope (3.8) needs to be substantially extended if gaps or loopholes are not to be created.

I am not clear how a Statutory Duty might apply to contracted out services/facilities management, independent or self-employed consultants/ contractors such as IT service providers/independent Social Workers etc.

Many, if not most, would not be directly involved in Candour/Openness interactions with patients but could well be caught by the **obstruction** offence referred to later.

Self-employment is a tax status. It confers no separate legal personality. The individual & their business are one & the same, neither an 'organisation' nor an 'employee' - & possibly even employers or sub-contractors themselves.

I specifically include IT service providers because there is tendency for services to be contracted-out as both hard & software become more specialised, sophisticated and resource intensive. *Duty of Candour & Being Open* is about sharing information/data. Access to or possession of data does not require direct contact with patients/clients. IT contractors can & do manage, analyse & store/warehouse corporate data on & off site. They may have knowledge of say use of non- official email accounts/ attempted editing or deletion of data – all potentially useful in situations of complaint/ dispute/non-compliance.

I have no knowledge of **Documents & Records Management protocols** within HSC but Documents are normally considered 'work in progress', held within the authors personal workspace with access limited to the author & any other parties they may nominate. Records on the other hand are finished work, uneditable, published and available to all with the required need/permissions.

Obstruction can be by omission or commission. Would holding a lot of information in (editable & deletable) documents in a personally controlled workspace be considered 'gaming the system' or obstruction by omission or commission?

Whilst much of the above may not be relevant to larger HSC bodies I suspect that it will be in relation to the multitude of smaller service providers.

Would in-house service providers be treated differently from external contractors?

I would note that all HSC contracts of employment or engagement must be subject to review to ensure applicability of NI law for a Statutory Duty to be enforceable. This requirement would need to be built into all Invitations to Tender, Requests for Proposals etc.

This requirement would also extend to the full range of contracts including all existing contracts of employment, including zero hours contracts, involving hundreds of private & voluntary sector organisations caught by Scope 3.8 bullets 2,3,4,5 and external contractors / suppliers.

As an example, my wife & I use different GP practices & guess what?

They use different service providers for their on-line services, neither of which appear to be based in NI

How exactly does 3.8 apply to voluntary organisations which are not regulated by RQIA in respect of member services such as advice & information, support & representation etc but are funded or part funded from the public purse in respect of all or some of their activities such as advice & counselling – accepting that not all such funding comes from HSC sources or DoH? Volunteers are not paid employees.

I also offer caution as to new/innovative methods of service delivery / provision are managed. There may be situations where service provision is only part provided by a body in 3.3-3.9

EXAMPLE FROM PERSONAL EXPERIENCE

(For the avoidance of doubt, I have retained the documentary evidence to stand-up anything I may say here or in further examples elsewhere)

Back in the early 2000's 'Supported Living' was flavour of the month

People with Learning Disabilities [redacted] from traditional care homes to smaller 2-3 person units. Care staffing was provided by the Trust.

The properties were however owned by a Housing Association which was responsible for the upkeep of the property and would therefore have potentially relevant information about the physical living environment, tenancy arrangements, churn etc.

My understanding is that these supported living establishments were out-with RQIA regulation for quite some time. Provision / management of accommodation may be integral to some Social Work/Social care packages.

Housing Associations appear to be outside the scope of the proposed Duty. Although possibly peripheral they may still have direct contact with tenants placed by HSC organisations & therefore some relevant knowledge.

I would also note that the same model of separation of ownership of property and management of operations is still prevalent in care home operations particularly large chains.

I simply make the point that new/hybrid models of care/service provision particularly those featuring some separation of management/control of assets from operations might be problematic when it comes to enforcing *Duty of Candour & Being Open*.

Routine Requirements (paragraphs 3.10 – 3.11)

5. Do you agree with the routine requirements of the statutory organisational Duty of Candour? If yes, please provide any additional information.

Yes in principle

3.10 clearly addresses Mr Justice O'Hara's intent to create statutory *Duty of Candour and Being Open* and does refer to both patients & service users.

Rules are explicitly created within the Statutory Duty concept. The purpose of rules is to reduce the role of judgment and, for better or worse, reduce 'wriggle room' They must be clear, specific & unambiguous – need consistency of purpose & intent and language across all settings especially if criminal liabilities are being created.

Regulations are the detailed 'by-laws' by which the rules are applied & enforced

Standards allow people to adjust to specific situations, to look at 'facts' and decide what is reasonable or appropriate but consistent with the Rules & Regulations

Guidelines work by decomposing complex decisions into bite sized chunks and sub-judgements along some pre-determined dimensions. They are about application of the Rules& Regulations in non-standard situations, they are not about re-interpretation of those Rules & Regulations.

3.11 (& 3.18,3.19,3.21,3.23,3.25,3.28,3.32,4.39,4.43 at least!) refers to 'further Guidance' to be issued by the Dept. In circumstances where organisational & individual criminal liability is involved that 'Guidance' must not in any way introduce inconsistency, ambiguity or doubt.

If he test in criminal law is 'beyond doubt', don't create that doubt in the first place!

See Example from Personal Experience in 6 below

Routine requirements are RULES and this needs to be reflected in the language:

PERFORMATIVE UTTERANCES ONLY IN THE INTERESTS OF CLARITY, ELIMINATION OF AMBIGUITY & CONSISTENCY WITH THE STATED OBJECTIVE OF CREATING DUTY & OBLIGATION.

IF YOU ARE CREATING CRIMINAL SANCTIONS THEN THE LEGISLATION MUST BE CLEAR & SPECIFIC – YOU CANNOT CREATE STANDARDS & GUIDELINES WHICH ARE IN ANY WAY AMBIGUOUS.

HEALTH v SOCIAL CARE

Rules aim to reduce the role of judgement.

That may be fine in medical/clinical settings where there are multiple 'objective' tests and established protocols/treatments, where skill & expertise might be more in spotting the exception than the normal.

Social Work on the other hand is almost entirely judgement based

For reasons in 7 below I have reservations as to how a common Statutory Duty might be applied *equitably* to both settings either as discrete functions or where overlaps exist.

6. If not, do you have a preferred approach for the routine requirements of the statutory organisational Duty of Candour? Please provide evidence to support any alternative proposal.

I have no alternative 'preferred approach' as such but throughout the IHRD Report there are multiple references to non-implementation, lack of knowledge of or perceived ambiguity around applicable Guidelines etc.

(The Kingston ICCIP Report @ p12 notes five Ofsted reports between 2007-20 referring to continuing patterns of ineffectual practice highlighting that 'lessons learnt' were not being embedded in practice)

IHRD at Vol 2 @ para 6.1, page 222 in the case of Conor Mitchell such issues are referenced as justification by the Minister for including the case within the scope of the Inquiry.

This situation is not limited to medical/clinical side, the H in HSC. It also infects the Social Work/Social Care side.

EXAMPLE FROM PERSONAL EXPERIENCE.

"The ISWA also advised me that the standards for assessment, care planning and discharge were not in keeping with those set out in the Quality Standards SSI1999 Assessment and Care Management. She highlighted that there was no comprehensive assessment on file even though the Standard for assessing Need states that when a comprehensive assessment is conducted, the contribution of all those involved are coordinated by one professional who produces an overview of the care needs and the users circumstances" – **Ombudsman's Investigation Report**

"...the Trust stated that its interpretation of the Quality Standards (Assessment & Care Management SSI 1999) is that there is not a specified requirement for the individual professional assessments of the multi-disciplinary team to be collated as a single document"

"there is no stipulation that this should be recorded on a prescribed document"

"The Trust view is that summarising individual professional assessments into one document could create the risk of dilution or misinterpretation of professional terminology or emphasis" -**Trust Chief Executive's response Quoted in Ombudsman's Investigation Report.**

Two entirely different & contradictory views of the same document! The Trust obviously perceived some ambiguity in the wording of the Standard. (Despite I suspect being involved in the consultation process preceding issue of the Standard)

The Ombudsman did not share their view. The outcome was a finding of Maladministration against the Trust – a finding in law.

The problem with that is of course that the focus is on what happened not why it happened and what made individuals act the way they did - culture /mind set?

The possibility is that every care assessment – potentially thousands- carried out under the Trust policy is open to challenge as Maladministration and may in fact be incorrect – It would make the Neurology recall seem like chickenfeed.

PERFORMATIVE UTTERANCES, UTTER CLARITY OF INTENT & CONSISTENCY WITH THE STATED INTENT OF CREATING DUTY & OBLIGATION

- NEED ABSOLUTE CLARITY & LACK OF AMBIGUITY ABOUT WHAT IS A RULE OR A REGULATION & THAT STANDARDS & GUIDELINES ARE ABOUT APPLICATION OF THOSE RULES & REGULATIONS NOT ABOUT THEIR RE-INTERPRETATION

As above also need comprehensive & robust channels of communication

Requirements – When Care Goes Wrong (paragraphs 3.12 – 3.18)

7. Do you agree with the proposed definition for the significant harm threshold for the Duty of Candour procedure? If yes, please provide any additional information.

I have multiple reservations about this section

Many of these revolve around the need for clarity, lack of inconsistency & ambiguity.

I also have an underlying concern that much of this Consultation is skewed towards the medical/clinical dimension of Health & Social Care whereas the intention is that the *Duty of Candour & Being Open* must apply to all aspects, settings & dimensions of Health & Social Care.

Need to recognise the 'power imbalance' both within and between professions. Equality of status, job titles, perspectives of individuals degrees/ levels of management responsibilities are all relevant. If one profession has a louder voice than others the risk must be that there will be misunderstanding within and across professions that could lead to either risk aversion or raised risk depending on the professions involved.

I would also add a significant reservation about the tendency to ***'medicalise'*** issues as happened in the Personal Example in 6 above. I would suggest that effectively cedes control to the senior medical consultant involved. My experience is that social

workers -at any level - are reluctant to challenge consultants & were aghast when I did so. Learning to challenge – and accept challenge – is going to be one of the keys in making *Candour & Being Open* work in practice.

The definition, recognition, perception even, of 'harm', never mind calibration of it as proposed will be quite different in the health & social care settings.

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8. If not, do you have a preferred definition for the significant harm threshold for the Duty of Candour procedure? Please provide evidence to support any alternative proposal.

3.12 & 3.13 LANGUAGE

Performative utterances only please in the interests of clarity and elimination of inconsistency and ambiguity. Consistency with the stated object of creating DUTY & OBLIGATION not semi-voluntary pick & mix options

There is a need for absolute clarity and lack of ambiguity as to what is a Rule or Regulation or a Standard or a Guideline

- See 5 above.

The Kingston Report above @ Enablers to Learning p34 notes

'Increase accessibility to all disciplines by ensuring that information from different agencies is translated into a common language'

(interesting also in light of Personal Example in 6 above)

For 'agencies' read medical specialisations, social work/social care, AHP's etc.- the analogy holds

That would seem to support the need for clarity, consistency & lack of ambiguity, cut the jargon.

3.14 EXCLUSION OF 'NEAR MISSES'

I totally fail to see the logic around the exclusion of near misses and my justification lies in the last 3 words-in this para – chance, prevention or mitigation

For the avoidance of doubt and being absolutely brutal, the IHRD came about precisely because five innocent children & their families were failed by chance, prevention or mitigation exactly when they most needed it.

They were further let down by organisational leadership & management and personal cultures and behaviours when it came to finding out what had gone wrong & why.

I believe it entirely reasonable that the same failures apply in the Neurology/ Muckamore/ Dunmurry Manor situations amongst othersl.

A 'near miss' is an 'almost mistake'. – doesn't matter if is omission or commission, nor moderate, significant, serious prolonged psychological harm

- A single near miss is one thing, a series is a totally different beast but how do you identify a series unless you actively look for it?
- The only way to avoid 'almost mistakes' becoming 'actual mistakes' is to systematically identify & collate the risk they represent, learn from them and manage them out to prevent or mitigate future risk by eliminating chance.
- This is simply good management practice and drives service and product quality improvement in incremental ways – ask any F1 team, aircraft manufacturer, (except maybe Boeing) pharmaceutical company, car manufacturer etc.
- Proactive is better than reactive for embedding positive values & behaviours.
- Just as bad practice resonates through the system and compounds itself so too does good practice!
- It is also good resource management, prevention is better than cure
- it also avoids large compensation claims with all the associated overheads & reputational risks for individuals & organisations.

The latter would seem quite important in terms of ability for HSE bodies to recruit & retain staff at all levels & of course justify their public funding, attract research projects & funding etc.

"There are the known knowns: there are things we know we know. We also know there are known unknowns: that is to say some things we do not know. But there are also unknown unknowns; the ones we don't know we don't know. And if one looks throughout the history of our country and other free countries it is the latter category that tend to be the difficult ones" – Donald Rumsfelt 12 dec 2002.

Substitute 'near miss' for unknow unknowns & Health & Social Care for country & other free countries.

The Kingston Report above recommended at 'Learning Culture and Training' p8

'A new reporting system needs to be developed that captures leaning from smaller incidents as well as major emergencies to better reflect the typical context of working practice (incremental and regular learning'

And at p38

'An organisation may experience thousands of 'low severity' incidents a year....an organisational 'incident learning system' should be in place which complements 7 tracks inevitable incidents that arise..... enables an organisation to extract useful information to build a picture of common themes over times thus enabling a more effective approach to ***embedding learning at all levels'*** (my emphasis)

Learning is an iterative process.

To put it another way – you need to know what you know before you can join the dots and learn from it.

EXAMPLE FROM PERSONAL EXPERIENCE

A number of years ago I attended an Outpatient Clinic [redacted] well known to us over a period of years.

At the end of the 10-15 minute session she proposed to prescribe SEROXAT

I intervened immediately and said that under no circumstance would I allow that.

In the terminology here that would be a 'near miss', an 'almost mistake', unrecorded, unnoticed - action taken, mistake averted, no harm caused etc.

But was it really?

There was no luck or chance involved in my presence at all review sessions!

- Seroxat had been prescribed several years ago
- Paradoxical reaction, it made aggression, 'agitation etc substantially worse.
- Involved a period in the Secure Assessment Unit at Muckamore where the only treatment was to manage out use of Seroxat & another drug
- We had made formal complaint to Down Lisburn Trust (DLT) that behavioural issues arose directly out of re-location from a traditional residential unit to a supported living unit & the *series of life events* associated with change of home, change of staffing support, change of house mates etc – the same stresses we

would all experience in a similar situation- but without the understanding /intellectual ability to cope with them.

- Our view was that this was not a psychiatric problem, didn't require medicalisation in the first place, required support not assessment in a secure unit.
- Seroxat was prescribed without our knowledge & in our view in inappropriate circumstances.
- Complaint was passed it to NWBSCT which ran then Muckamore & investigated by [redacted] who accepted our views & at our request submitted a Yellow Card Adverse Reaction Report to MHRA.
- In correspondence from the Chief Executive of DLT we received apologies & were asked if we had any suggestions to prevent such situations in future.
- I suggested that every Review Meeting must start with a review of meds, any changes & any issue arising. I have a letter from DLT Chief Exec agreeing & committing to issue appropriate instructions
- At subsequent meetings, some attended by the Muckamore consultant, it was clear that no such instruction had been issued & certainly not applied.
- I argued the point & handed out copy of CE letter & finally at the start of one meeting openly made a mobile call to the Trust HQ & asked for Chief Exec's office! (Problem solved in our case – no idea about others)
- The psychiatrist was well aware of all this & made clear at a meeting that she did not agree with [redacted] view & that Seroxat was a great drug!

As I say above, under your process my intervention would be a 'near miss' -really?

SUGGESTION

A 'Shared Learning' web site to allow all staff & indeed service users to log 'almost mistakes' & the preventative/mitigating actions taken to prevent them becoming 'actual mistakes'.

From reading elsewhere I believe the US Veterans Administration has done work in this area.

3.15 DEFINITION OF HARM

I have serious reservations about this on several grounds, partly covered above iro 'near misses'

- consistency of application across all HSC settings

- consistency of definition & perception of 'harm'

In respect of the definition of 'harm' there are at least 8 definitions in the Glossary which suggests some ambiguity and lack of clarity.

The policy of Candour & Being Open is intended to apply across all HSC settings.

I presume it is intended to be applied equitably across all settings.

I note however that in 3.15 the only examples of serious harm appear to be medical or clinical related actions.

I see nothing which might apply in Social Work/Social Care settings.

I do note the 'prolonged psychological harm' definition. That itself raises obvious issues:

- DSM IV outlines criteria for diagnosis of depression - 5 out of 8 symptoms (inc 1 of 2 specific symptoms), not the result of another medical condition, experienced over a two week period so why opt for 28 days?.
- Is prolonged psychological harm moderate or serious?
- What is the time frame for its presentation/diagnosis/progression or treatment?
- Given the different duration of (most) health or social care interventions are there implications for fair & equitable application of *Duty of Candour & Being Open* & would there be differential resource implications?
- I raise these issues simply to suggest that in this area there will be no hard & fast objective diagnostics,
- diagnostic will be an art form not a science & as with all art, beauty is in the eye of the beholder!

<u>HEALTH CARE</u>

Looking at the broader medical/clinical care area there is an abundance of replicable & repeatable & recordable & reportable diagnostic tests and indeed treatments/ drugs /surgical protocols.

- Blood pressure, pulse, temperature, X-Rays, ECG's EEG's, MRI scans, blood tests, urine tests etc are objective & universal
- There are established markers and indicators for many conditions, illnesses & elective, curative or emergency surgical interventions & events.

For many medical conditions diagnosis is routine if not almost mechanical with rules and procedures in place to minimise the 'noise' inherent in exercising judgement. Some conditions such as broken or dislocated bones are easy, visually apparent.

Although there are flexibilities & discretions in relation to interpretation & diagnosis there are in fact many boundaries within which these are exercised. The rise of remote IT/AI learning monitoring & diagnostic kit adds a further dimension to the flexibility of boundaries.

SOCIAL WORK AND SOCIAL CARE on other hand do not have the same battery of replicable, repeatable, recordable diagnostics nor IT/AI/algorithms available.

What they do have however are STANDARDS of Conduct & Practice

Both social work & social care are intrinsically based on judgement and personal/social interactions in which 'noise' plays a big part

- context/location/individual moods of all involved play a part in arriving at an assessment no the day, no two assessors will have identical experience, personality, knowledge, expertise, life experiences, workloads etc

No social work or social care interaction can therefore ever be replicated. They can be repeated but not consistently in the way that say monitoring of an individual's blood pressure can be over time and geography independently of the assessor.

Assessments are therefore very personal & subjective, matters of opinion and judgement without the hard objectivity of replicable & repeatable tools available in medical/clinical settings.

Quality, accuracy & comprehensiveness of record keeping is absolutely vital though I'll bet no assessor will ever record their own personal feelings/moods/ prejudices/ biases etc at the time of an assessment & consider how those might affect their judgment – all that noise will be ignored.

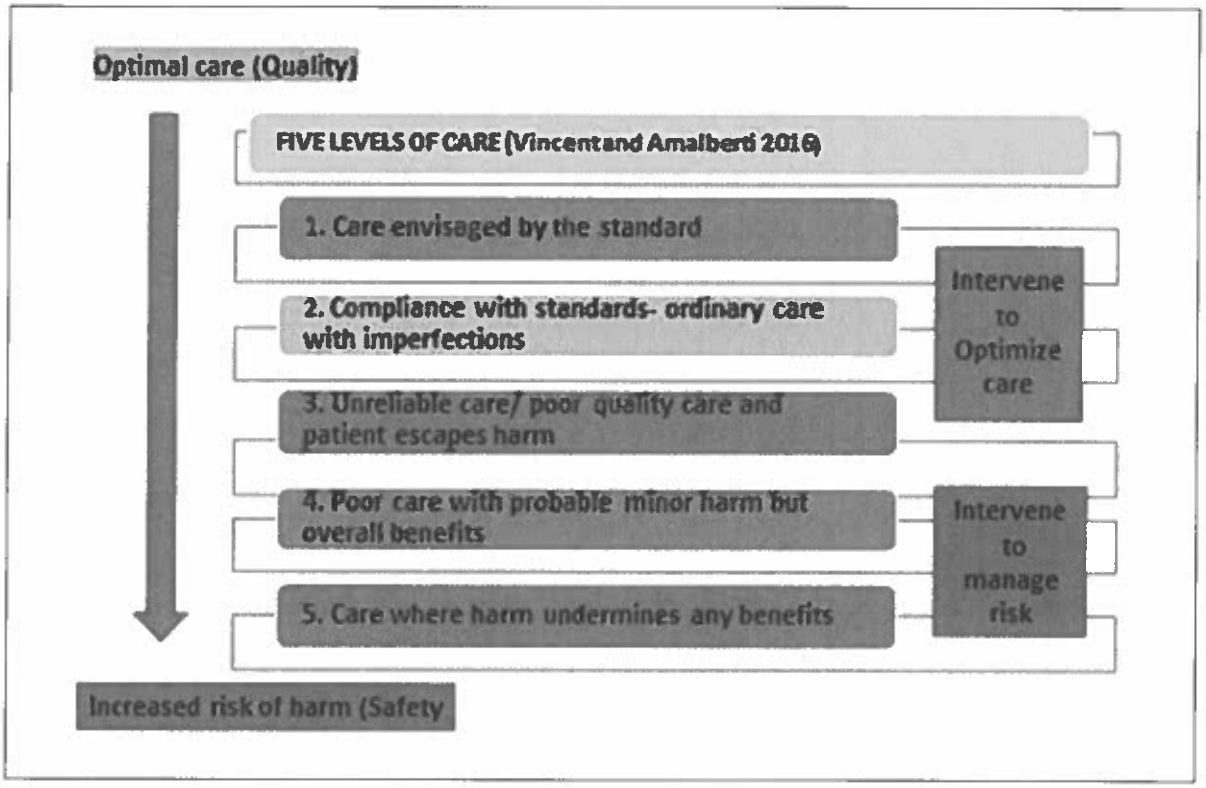
As in 5 above, a Statutory Duty implies Rules & Regulations intended to limit exercise of judgement. Social Work is entirely judgement based.

Clinical /medical care applies judgement to replicable & repeatable diagnostics with a clear menu of treatment options & predictable outcomes – there are boundaries.

Taking the above into consideration I have considerable difficulty seeing how definitions in 3.15 can be applied equitably to both the Health & Social sides of HSC

I can only suggest consideration of the **Five Levels of Care** model attached with tweaks to reflect the different needs & perspectives of the Health & Social Care arms of HSC – they just are not the same.

Might equally be applied across the board to handling & classification of complaints or indeed 'near misses'/ 'almost accidents'



Statutory Duty of Candour Procedure (paragraphs 3.19 – 3.23)

9. Do you agree with the proposed requirements under the statutory organisational Duty of Candour when things go wrong? If yes, please provide any additional information or insights.

Footnote 14 on page 27 refers to 10 days or sooner as a guideline for reporting incidents to patients or duly authorised representatives.

This may be practical in relation to the 'serious harm' medical issues in 3.15 which might be readily identifiable by HSC professionals & patients/carers/family.

In the case of Social Work or Social Care what will be the trigger for 'becomes aware' – contact or complaint about specific action/event, a phone call questioning a decision', refusal to agree to or sign off a care plan etc?

What is the timescale for triggering 'becomes aware'?

Where there are obligations to inform regulators or professional bodies about events then patients/carers etc should be contacted at the same time & with the same information as provided to the regulators.

I would also refer you to the NI Ombudsman's Annual Report 2019-2020 which notes that of 1043 complaints handled during the year 377 or 36% came from the HSC sector, of which 298 related to HSC Trusts. I quote:

"As in previous years a high percentage of cases at investigation related to health and social care issues. This reflects the Ombudsman's different jurisdiction in the sector, in that the Ombudsman is also able to examine the merits of a decision taken by health and social care professionals *as well as investigate allegations of service failure."*

I am not clear how a *Statutory Duty of Candour & Being Open* with criminal liability attached can operate alongside this power of the Ombudsman. It would suggest both double jeopardy and a return to the blame culture across the board totally undermining a key element of the *Candour & Being Open* concept.

I also refer to the currently open NIPSO Consultation *'Consultation on creating complaints handling standards for the Northern Ireland public sector'* which seems to tramp all over this consultation. Back to standards not statutory duties?

NIPSO confirm in correspondence that their proposed Model Complaints Handling Procedure will carry the status of statutory obligation. There can be no guarantee that it will 'fit' around *Candour & Being Open*

Being candid & open there seems to be a total lack of coordination here and multiple grounds for confusion, inconsistency & ambiguity – utterly stunning!

10. If not, do you have a preferred approach for the requirements under the statutory organisational Duty of Candour when things go wrong? Please provide evidence to support any alternative proposal.

In the event of an incident there is a need for immediate evidence gathering from those involved, preferably before they have any opportunity to discuss it with other team members. It is the old psychology thing about eye- witnessing & co-witnessing – in any situation people will focus on things of interest to them but given the opportunity to discuss with others will subsequently alter their recollections to incorporate stuff they didn't actually see but which they consider plausible given the source of the 'new information'. The more expert/ respected/trustworthy the source the more credibility it may be given & potentially the more corrupted or distorted recollections become precisely at the time when they become more similar.

A narrative becomes accepted & established even as its foundations become shakier

This is not collusion, it is just plain psychology – People see what they expect to see & then recall what they are asked to recall. Focus is narrow, peripheral vision is broader & it is action in this area which is probably more susceptible to variation.

Think of the old video of two teams passing a basketball around & watchers being asked to count the number of times a blue or white player touches the ball. Normally no-one notices the gorilla wandering in & out of shot until it is mentioned before video is replayed.

Evidence gathering is important & requires a much more robust approach & more attention than currently given.

I would reference comments In IHRD Vol 2 – Raychel Ferguson Page 206 @ 5.333

' It is hard to conceive that these witnesses could have agreed one thing at Critical Incident Review and then said another at inquest had the Critical Incident Review been recorded and a report prepared'.

In the light of my comments above it is not remotely surprising that recollections or statements vary over time – and that is without impuning any malign or malignant motives.

Apologies (paragraphs 3.24 – 3.26)

11. Do you agree with the proposed legislative requirement to provide an apology as part of the Duty of Candour procedure? If yes, please provide any additional information or insights.

Hard to disagree about the need for apology, it is the minimum requirement.

Equally human nature being what it is there will be a formulaic approach to it – it will be' trained into' the staff dealing with the issue & not left to free-hand.

Substantially driven of course by case law.

12. If not, do you have a preferred policy approach in respect of apologies in circumstances where the threshold for the Duty of Candour procedure has been met? Please provide any evidence to support any alternative proposal.

Applying Candour & Being Entirely Open here, we all know that no matter whose signature an apology is issued under reality is that the actual drafting will be done by nominated admin /support staff and particularly those involved in any investigation/ complaint process. We also know that given the scope & scale of the change under Consultation there will be extensive staff training required across a range of bodies & avoiding a 'sameness' will be all but impossible, it will be 'trained in' to people (probably by the same trainers/consultants) -no point avoiding the issue!

3.25 – I do note the comments about 'in person' – understandable but again, being realistic this will be delegated to an appropriate 'volunteer' or nominee. We need to recognise that no matter how genuinely sorry some people may be about an event they just might not have the personality & communications skills to carry off a genuine & sincere apology & might do more harm than good.

13. Do you agree with the proposals in respect of apologies under the statutory organisational Duty of Candour? If yes, please provide any additional information or insights.

An apology should be just that, nothing more.

Problem is that you cannot legislate for Common Law case law – it will always be possible for some sort of 'read across' from law in other areas such as data protection, FOI etc. It is simply what lawyers & judges are paid to do!

HSC cannot be hermetically sealed off from that.

14. If not, do you have a preferred approach for the proposals in respect of apologies under the statutory organisational Duty of Candour? Please provide evidence to support any alternative proposal.

No suggestions

Support and protection for staff (paragraphs 3.27 – 3.28)

15. Do you agree with the proposals for support for staff under the statutory organisational Duty of Candour? If yes, please provide any additional information or insights.

You need to carry staff with you in order to make transformational change work.

Part of that requires clear commitment from management.

CLUE is in the title – *Duty* of Candour and Being Open - language needs to reflect this, no opportunity for interpretation or ambiguity

16. If not, do you have a preferred approach for the support for staff under the statutory organisational Duty of Candour? Please provide evidence to support any alternative proposal.

No suggestions

Reporting and monitoring (paragraphs 3.29 – 3.32)

17. Do you agree with the proposed reporting and monitoring requirements under the statutory organisational Duty of Candour? If yes, please provide any additional information.

NO! Performative utterances only, language needs to be consistent with the purpose & the intent to create DUTY and obligations

Requires commitment, it's **rules and regulations.**

3.29 'Provision ~~should~~ WILL be made…" etc

I would also draw attention to comments above re IT/ Documents & Records Management, Gaming the system & Omission & Commission

3.30 "It ~~should~~ WILL be a statutory requirement…" etc

18. If not, do you have a preferred approach for the reporting and monitoring requirements under the statutory organisational Duty of Candour? Please provide evidence to support any alternative proposal.

3.30 – Reporting/ monitoring must be at least quarterly if not monthly to be of any practical use, needs to be timely not merely historic if any meaningful learning value is going to be extracted or indeed any impact on risk reduction.

Must be a Board Agenda item - Risk Register and for 'public' not closed sessions.

3.31 need to expand the circulation list to include the **NI Social Care Council, Patient & Client Council & Ombudsman's Office**

- all have an interest, NISCC as registration/regulation of Social Work & Social Care, the others having a broader public interest role.

- I include the Ombudsman's Office because they see a role for themselves in helping Trusts in 'managing complainant expectations'

Neurology recall /Muckamore/Dunmurry Manor situations did not simply appear fully formed, they will have had a long gestation.

Patterns of abnormal, unusual or inappropriate behaviour or events may well be indicators or markers of emerging problems/ issues.

Issue is as always no-one knew what they knew & could not join the dots

I would also note that the various Royal Colleges & Professional Bodies are in effect 'regulators' in their own areas, difficult to see why they should be excluded from any circulation lists.

Criminal sanctions for breach (paragraphs 3.33 – 3.40)

19. Do you agree with the proposed criminal sanctions for breach of the statutory organisational Duty of Candour? If yes, please provide any additional information.

Broadly in favour of the concept, reservations below

As regards level of fine etc I think there needs to be consideration of the 'market rate' across various legislative provisions.

Organisations however have 'directing minds' & organisational breach will be the sum of the actions of a number of these – seems unfair, counterproductive even to punish the whole for the actions of a few.

20. If not, do you have a preferred approach for the criminal sanctions for breach of the statutory organisational Duty of Candour? Please provide evidence to support any alternative proposal.

3.34 I am far from convinced that RQIA is the most appropriate body to have oversight of Duty of Candour compliance.

- 3.8 lists RQIA as one of the organisations subject to Duty of Candour compliance, you cannot regulate yourself, mark your own homework, I have an Ombudsman's Maladministration finding relevant in this regard!

I also draw your attention to ***Principles of Good Complaint Handling*** – by analogy, the closest to Candour & Openness handling at the moment which specifically requires under the ***'Acting fairly and proportionately'*** heading "Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint"

I would suggest that being both subject to a Duty of Candour and Openness whilst at the same time being its compliance adjudicator/monitor in respect of other organisations suggests a very reasonable risk of conflict of interest.

Even a perception of this would undermine confidence in the entire process at the outset.

Recent experience with Post Office / RSPCA /Serious Fraud Office rather suggests power of prosecution cannot lie with bodies without considerable legal resource & specific & significant experience in criminal law prosecution - in some cases perhaps not even then!

Draw up case papers by all means but **criminal** prosecutions as opposed to civil actions by PPS or with Attorney General approval only.

Obstruction offence (paragraphs 3.41 – 3.42)

21. Do you agree with the proposed obstruction offence under the statutory organisational Duty of Candour? If yes, please provide any additional information.

Yes subject to usual Performative utterance – WILL not ~~should~~ etc!

I would also refer to comments above re the scope of Organisational Duty re Outside contractors/ external facilities managers etc and also the issue of documents v records & gaming the system.

22. If not, do you have a preferred approach for the obstruction offence under the statutory organisational Duty of Candour? Please provide evidence to support any alternative proposal.

I observe that there is already a body of common law around perjury, misconduct, malfeasance /misfeasance in public office.

My understanding is that the courts would have to take cognisance of this in any cases coming before them – lawyers certainly will.

Remembering that the proposal is to create criminal sanctions it must be stressed that the standard of proof there is 'beyond doubt' whereas civil law is based on reasonable doubt. It is a very high bar.

Because of that I suspect than very, very few cases will ever proceed to court, the vast majority being dealt with at the performance review/ disciplinary level

Additional feedback

23. Is there any additional evidence, or observations that you wish to provide in respect of the policy proposals for the statutory organisational Duty of Candour?

I have made previous references to Performative Utterance, need for clarity, lack of ambiguity etc.

I do reiterate my concerns/objections to the proposed role of RQIA in oversight & prosecutions in 20 above.

I would note Justice O'Hara's remarks and observe that:

- RQIA is in fact part of the existing oversight mechanisms within HSC which have collectively not been sufficient to ensure that candour takes place.

- being both subject to *Duty of Candour & Being Open* rules in respect of its own operations whilst exercising oversight of compliance by other organisations raises conflict of interest considerations

Principles of Good Administration & Principles of Good Complaint Handling would seem relevant.

I must also reiterate my concerns that much of this consultation document seems tilted towards the Health side of HSC: not unreasonable given the origins of IHRD but nevertheless unbalanced.

Statutory Individual Duty of Candour (Section 4)

Policy Proposal – Statutory Individual Duty of Candour with criminal sanction for breach (paragraphs 4.13 – 4.22)

24. Please provide comments on the policy proposal for the statutory individual Duty of Candour.

I cannot see any objection in principle to a statutory Individual Duty of Candour – it is similar to individual responsibilities under Data Protection legislation and indeed much of the Financial Services legislation enacted since 1974 for example.

Whilst appreciating that *Duty of Candour & Being Open* relates to interactions between staff & clients/patients/service users how does this interact with other duties such as under Data Protection/FOI/Whistleblowing?

Would knowledge of Whistleblowing be disclosable/? Presumably it would if it related to matters attached to treatment options etc.

How would this impact Whistleblower protections?

4.14 I note the reference to 'staff' within the scope etc. I assume this will extend to the self-employed/independent contractors or consultants involved in HSC provision (staff substitution) I appreciate that this is referred to in Footnote 26- it is not just contracts of employment but contracts for services with Locum/Staffing Agencies, Invitations/ Requests to Tender & the whole public procurement process in effect.

4.18 I note that this para. sets a very high bar for criminal prosecutions, probably in fact so high as to effectively neutralise the threat of prosecution.

4.19 The range of sanctions at the sub- criminal liability standard need to be sufficiently robust & effective at discouraging non-compliance as they will in practice be the only sanctions deployable. In criminal law the bar of proof is beyond doubt, in civil cases it is reasonable doubt.

How for example does 'Professional Regulation' kick in in respect of staff who are either not members of professional bodies or of bodies outside NI?

How many Royal Colleges or Professional bodies would be represented within any single medical or surgical team? How many on a Multi-Disciplinary team?

How many different Codes of Conduct or Practice would be involved?

Would there be consistency of approach across all?

Are all staff - managers/ IT staff /Complaints Managers, ward clerks etc members of Professional bodies? If not the range and significance of potential sub-criminal liability sanctions changes substantially.

I do not recall any proposal to exempt certain categories of staff from the full rigours of the Statutory Duty. Would this require different contracts of employment for example?

The sad thing here is that the emphasis is on the negative / reactive aspects of *Duty of Candour & Being Open,* the need for 'support mechanisms to protect staff' etc

There are initiatives already in play – Shared Decision Making/Co-Production for example – where proactive 'applied Candour & Being Open' might well prove transformational to service provision, not least because they bring external voices, experiences & attitudes to the table and more importantly external challenge.

I can fully understand the concerns organisations / staff & their representatives may have about the concept of criminal liability.

I have c40 years practical experience of providing care & support to someone [redacted] I have had contact with a regiment of doctors/nurses/social workers/care assistants/AHP's etc. I have sat through countless case conferences/meetings/ reviews etc. I have (successfully) taken up a number of complaints including to the Ombudsman.

I have seen the good, the bad and the frankly ugly side of HSC provision over that c40yrs.

I cannot recall any instance of a case conference/review in which there was serious disagreement between the professionals around the table. Maybe they did all absolutely share exactly the same views at all times – or was there a culture of total deference & conformity?

I equally remember many conversations where HSC staff have said that they would never want to be admitted to certain hospitals or wards, be treated by certain GP's or consultants, depend on certain social workers or care providers – all hearsay of course but the patterns are there.

Candour & Being Open in Shared Decision Making/Co-production etc offer opportunity to address some of the dissatisfaction and negative attitudes which provide the background noise in HSC provision.

There needs to be serious positive messaging to achieve this, not least to overturn the widespread feeling that 'taking the learning' is basically a well established short hand for avoiding taking personal responsibility for mistakes & errors.

There is an opportunity for real influence & input to HSC service delivery by staff & patients/service users. It will be a mammoth task though. I have stressed lack

IHRD Vol 2 Conor Mitchell 6.12 @ page 222 & subsequently would be relevant consideration.

Alternative Policy Proposals (paragraphs 4.23 – 4.35)

25. Please provide comments on the alternative policy proposals for the statutory individual Duty of Candour.

The alternative policy proposals have their attractions but their failures are encapsulated in 4.24 – comments on the weakness in ethical duty & indeed reinforced in the Kingston University Research report – it may be 7 years old but I doubt that much will have changed (sadly).

Opting for a Statutory Duty is very much the last throw of the dice, the last big stick- if this fails it is hard to see what other weapons remain in the armoury

26.. If you do not agree with any of the three high-level policy proposals, do you have a preferred alternative policy approach for implementation of the recommendations relating to the statutory individual Duty of Candour? Please provide evidence to support an alternative proposal.

No alternative suggestions

Scope (paragraphs 4.36 – 4.38)

27. What is your preferred policy approach in respect of the scope of the statutory individual Duty of Candour? Please outline the reasons for your preference, and provide evidence to support your reasoning.

In 3 & 4 above relating to statutory organisational Duty of Candour I have indicated that the scope may not be entirely adequate.

I think much the same considerations apply here to individual Duty.

In the Recommendations at 1(i), 1(ii), 1(iii), 1(vi) & 1 (vii) references is made to patients.

Applying the vernacular perception of a patient as someone with medical/clinical issues this would seem to exclude that broad swathe of people often referred to as service users – those receiving social care packages, addiction counselling, in fact any non-medical support intervention probably including psychological / counselling support!

This is clearly inconsistent with the aim of applying a Statutory Duty across the whole spectrum of HSC services.

Is 'patient' to be defined narrowly or does it extend to 'service users'?

Risk of inconsistency & ambiguity needs to be addressed here!

Routine Requirements & Requirements When Care Goes Wrong (paragraphs 4.39 – 4.43)

28. Do you agree with the proposals in relation to the requirements under the statutory individual Duty of Candour? If yes, please provide reasons for your agreement.

I agree with the proposals. My reason for agreement? Practical experience over c40yrs!

EXAMPLE FROM PERSONAL EXPERIENCE

[redacted]

Complaint went through the internal Trust complaints procedure then on to the Ombudsman who issued report in March 2017. (Finding in our favour on all substantive issues -7 out of 9)

The process was long, protracted, distressing beyond measure, intensely confrontational & frankly unacceptable

When the Ombudsman asked the Trust for documents the Trust simply dumped 6 or 7 boxes of documents at their offices.

When the Ombudsman asked the Trust for specific information they were on several occasions unable to provide it (Fortunately I had my own records & was able to provide dates & indeed copies of Trust documents)

Bluntly the Trust did not appear to know what it knew, could not connect the dots and seemed to make little or no attempt to co-operate with the Ombudsman.

Further, on the day the Ombudsman's Report was due to be released the Trust decided to query my 'standing' in the complaint, [redacted]

With Candour & Openness the whole matter could have been resolved in a fraction of the time -and at a fraction of the cost to the HSC.

It might even have lowered my blood pressure and perhaps tempered my deep scepticism about HSC complaints handling.

29. If not, do you have a preferred approach for the requirements under the statutory individual Duty of Candour? Please provide evidence to support any alternative proposal.

No alternative proposals

Exemptions (4.44)

30. Do you have any comments to make on the case for exemptions from the requirements under the statutory individual Duty of Candour? Please provide evidence to support your position.

I cannot provide 'evidence' as such.

Clinical or professional judgement & information/data sharing would seem to be at the heart of the *Duty of Candour & Being Open.*

There may indeed be cases where exemptions may be justified.

I would suggest however that this will be rare and rather than 'blanket' exemption in the legislation perhaps the option should exist for a context/situation specific application/ referral or appeal to an **independent adjudicator / tribunal/panel** able to seek legal or professional advice as required and make binding decisions as to fact, interpretation or application.

For the sake of consistency there must be a single point of contact for all within the scope of the Statutory Duty.

Best to seek exemption & make the case rather than assume it.

Additional Feedback

31. Is there any additional feedback that you wish to provide in respect of the policy proposals for the statutory individual Duty of Candour? If so, please provide evidence to support alternative proposals, if possible.

I refer to comments above derived from c40 years practical experience in a caring role.

I can appreciate individuals having concerns about the impact of a *Duty of Candour & Being Open.*

There is however absolutely nothing new, novel or unusual about it.

Virtually every member of HSC staff from newest porter to Chief Exec or Director *(INCLUDING YOU, THE READER)* will have experienced Candour & Being Open in practice.

Based on 33+ years of experience in banking & finance I think back to the Consumer Credit Act 1974 & the plethora of Financial Services & Markets legislation since then, much based on reaction to various scandals, crisis etc.

Objectives – consumer protection via information gathering & sharing in the interests of finding the most suitable product available to meet identified need & agreed risk & affordability profile. It is a two-way sharing/ questioning process (done properly).

Financial services organisations are regulated and licensed. Individuals are regulated, registered and licensed. Both face a range of civil & criminal liabilities as well as sanctions from professional bodies. All the information provided to consumers – interest rates, fees, commissions, product descriptions, risk factors are nothing more than *'Candour & Being Open'* in practice!

If you have bought a mortgage, loan, credit card, pension, investment or insurance product any time in the last 30+ years you will done so after going through the process of fact find /financial health check, your credit score is only an indication of financial health.

I believe the analogy to be a strong one.

Being Open Framework (Section 5)

Policy Proposals (paragraphs 5.1 – 5.8)

32. Do you agree with the policy proposals in respect of the Being Open Framework? If yes, please outline your reasoning.

The policy proposals seem eminently sensible. Not only do they reflect the findings of the IHRD they speak eloquently to issues uncovered in multiple inquiries into many health & social care related events.

They will I suspect be equally eloquent in respect of other on-going inquiries – Muckamore/Neurology/Dunmurry Manor etc.

5.2 makes reference to mechanisms to facilitate cultural change.

This document gives the impression that there is a single culture across all HSC settings. There is no such thing. There are I believe some 600-700 separate bodies involved in providing HSC services: each will have its own culture/values/behaviours.

Larger organisations such as Trusts will have multiple cultures/ sub cultures as will the various specialisms, not to mention Depts, wards, teams, individual shifts etc.

Individuals will experience culture like a layer cake and treat it as such

– take the layers you like and ignore/discard the ones you don't.

Policy is fine – execution will be the big issue. There cannot be multiple interpretations of Duty – not when criminal liability is involved.

It may be necessary to remove some delegated authorities from some arms-length bodies in order to enforce compliance.

Getting multiple organisations on board will be like herding cats.

The way forward will require the incorporation of *Duty of Candour & Being Open* into tenders/contracts as a 'social good' consideration.

33. If not, do you have a preferred policy approach in respect of openness and candour in health and social care? Please provide evidence to support alternative policy proposals.

Level 1 – Service Users and Carers (paragraphs 5.9 – 5.11)

34. Do you agree with the policy proposals at Level 1 of the Being Open Framework for Service Users and Carers? If yes, please outline your reasoning.

Content with the broad principles but as always there is the language/tone

5.9

The intent is that service users will be treated as partners in their care to the extent that they want to be- it's a DUTY, an obligation not an option but see below.

'Should' creates ambiguity, it conflicts with the WILL in all bullet points and also 5.9 & 5.10

Consistency of language removes ambiguity.

5.9 refers to easily understandable information – a greater investment in Healthcare Literacy alongside implementation of statutory duties might be useful for both staff & service users/patients.

HEALTH v SOCIAL

It is relatively easier to see how information can be communicated in the medical/clinical setting.- charts, test results, X-rays, scans, drug & surgical protocols all with a relative high degree of confidence iro diagnosis, potential treatment & outcomes.

Pictorials - charts of temperature/blood pressure/X-rays etc – are easier to 'read' even by a lay person because they highlight anomalies, trends, broken bones etc. without the need for verbiage/jargon.

They are also replicable & repeatable.

It is harder to see how and what information may be shared in the 'social' side of HSC. There are no pictorials. Its pure prose - subjective opinions, point in time assessments and justifications of those without the option of replicating the context in which they were made, no validation except further observations over time & assumptions drawn from those. It is also a matter of personal opinion as to how what & how much information is recorded & thus potentially shareable.

How far back do you go for information?

How is SW information stored – paper or electronically?

How do you present information at a Candour & Being Open encounter- hard or soft copy?

Can existing information management systems actually cope with likely demands?

35. If not, do you have a preferred policy approach in respect of Level 1 of the Being Open Framework for Service Users and Carers? Please provide evidence to support alternative policy proposals.

I have referred elsewhere to an Ombudsman's Report.

Policy approach is understandable, acceptable but that does not carry any certainty that it can be delivered

The report identifies multiple instances – going back to 2000 of Maladministration in respect of record keeping including:

Records did not confirm that care plan were derived from assessed needs

Quality of care plans was inadequate, not fully completed, dated & signed by Social Worker & Care Manager

No evidence of having been QA's by senior managers

Multiple instances of conflicting justifications/explanations for decisions

Difficulty seeing how actions agreed at one meeting were followed up by the next meeting

Breaches of Codes of Practice for Social Care Workers & Employers of Social Care Workers

This goes straight back to issues I have raised in 5 above, & indeed throughout this input – confusion, inconsistency and ambiguity as to what is a Rule or Regulation and what is a Standard or Guideline – an obligation or an option.

Level 1 – Staff (paragraphs 5.12 – 5.13)

36. Do you agree with the policy proposals at Level 1 of the Being Open Framework for Staff? If yes, please outline your reasoning.

Again, content with the broad principles but the language is inconsistent with intent of creating DUTY & obligations.

5.12

In this instance the organisation will have legal duties and obligations to support staff. Therefore staff will:

- receive time & opportunity etc..

- be given time etc

- have clarity etc

- be managed etc

5.13

Header is *What is required of HSC staff* not what is expected – best to be clear, consistent & unambiguous -**Rules & Regulations not Guidance**

37. If not, do you have a preferred policy approach in respect of Level 1 of the Being Open Framework for Staff? Please provide evidence to support alternative policy proposals.

Level 1 – Organisations (paragraphs 5.14 – 5.15)

38. Do you agree with the policy proposals at Level 1 of the Being Open Framework for Organisations? If yes, please outline your reasoning.

Again, content with the broad principles but the language is inconsistent with intent of creating DUTY & obligations.

The Dept is covered by the requirement of *Candour & Being Open*, in this case to the various arms-llength & operational bodies involved in service delivery (& through them to their multitude of sub-contractors)

The Dept must be seen to lead the charge and honour its own obligations in respect of guidance, policy & procedure development, commitment to staff and provision of leadership.

It must **enforce** a single 'interpretation' of the Rules & Regulations around *Duty of Candour & Being Open*

Clarity, consistency & no ambiguity. – Rules where necessary, Standards and Guidelines where appropriate but audited for consistency & lack of ambiguity

5.15

Bullet points all refer to duties & obligations, no 'expectations' just obligations.. Language and tone must reflect this

39. If not, do you have a preferred policy approach in respect of Level 1 of the Being Open Framework for Organisations? Please provide evidence to support alternative policy proposals.

Level 2 – Service Users and Carers (paragraphs 5.18 – 5.19)

40. Do you agree with the policy proposals at Level 2 of the Being Open Framework for Service Users and Carers? If yes, please outline your reasoning.

:

Fully accept the concept of Openness to promote learning but I will stick with my comments in 7 above

Being brutal, the Hyponatraemia Inquiry Report came about precisely because five innocent children & their families were failed by chance, prevention or mitigation exactly when they needed it.

You need to know what you already know before you can join the dots, see any patterns and learn from them to prevent and mitigate risk.

5.18

Three bullet points refer to learning from near misses but I cannot see how this will be achieved without some form of recording/reporting/monitoring. By definition 'near misses' or 'almost mistakes' are the closest opportunity for proactive learning whereas moderate, severe or prolonged psychological harm are all entirely reactive and will be documented/recorded/analysed extensively.

Common sense says better to prevent rather than cure

5.19 A *Candour & Being Open* interaction cannot be a monologue & yet patients/service users/ carers cannot be in any way forced to participate. Even if they do there will probably be a high degree of deference to the opinions of the healthcare professionals. People living with long term conditions will probably be quite well informed as to the reality of their situations.

In all walks of life things tend to go better when everyone is on the same page – there might be benefit to a broader campaign of Healthcare Literacy, making more information readily available to /accessible to the general public.

41. If not, do you have a preferred policy approach in respect of Level 2 of the Being Open Framework for Service Users and Carers? Please provide evidence to support alternative policy proposals.

Level 2 – Staff (paragraphs 5.20 – 5.21)

42. Do you agree with the policy proposals at Level 2 of the Being Open Framework for Staff? If yes, please outline your reasoning.

The substance is fine but the tone is not.

If staff are required to act in a particular way there is an obligation & requirement on the employing organisations to support them in doing so – obligation not expectation, a right to receive.

43. If not, do you have a preferred policy approach in respect of Level 2 of the Being Open Framework for Staff? Please provide evidence to support alternative policy proposals.

Level 2 – Organisations (paragraphs 5.22 – 5.23)

44. Do you agree with the policy proposals at Level 2 of the Being Open Framework for Organisations? If yes, please outline your reasoning.

5.22 To comply with a statutory obligation HSE organisations will require not expect staff to be open & candid etc.

5.23 " As a minimum it is expected that: " – no – will be required to, it's a rule, a direction not an option

45. If not, do you have a preferred policy approach in respect of Level 2 of the Being Open Framework for Organisations? Please provide evidence to support alternative policy proposals.

Level 3 – Service Users and Carers (paragraphs 5.26 – 5.29)

46. Do you agree with the policy proposals at Level 3 of the Being Open Framework for Service Users and Carers? If yes, please outline your reasoning.

Broadly acceptable but language is ambiguous.

5.26 – First sentence - Ambiguous language – Statutory duty obligation – don't 'expect' but will receive

Footnote 39

See 3 above.

I have long felt that Investigations /complaints handling in general should be independent of the Trusts at all times!

I also think that there needs to be a core team of experienced investigators available to do initial information retrieval as rapidly as possible when a need to do so is identified.

The more serious the event the greater the need!

I have referred to above to a possible role for an independent external tribunal to rule on exemptions.

On balance I am coming to the view that an independent external entity such as the NIPSO should have the power to 'call in' serious events at the outset & actively manage /oversee investigation.

At the least it would shorten the process which is bound to have resource implications across the HSC system.

More importantly it would address needs of patients/service users/ carers to see timely resolution of issues.

47. If not, do you have a preferred policy approach in respect of Level 3 of the Being Open Framework for Service Users and Carers? Please provide evidence to support alternative policy proposals.

Level 3 – Staff (paragraphs 5.30 – 5.31)

48. Do you agree with the policy proposals at Level 3 of the Being Open Framework for Staff? If yes, please outline your reasoning.

Agreed in principle but ambiguous & inconsistent language needs addressed

5.30 Ambiguous language – Statutory duty obligation – don't 'expect' but 'will receive'

5.31 Ambiguous & inconsistent language – Statutory duty obligation – don't 'expect' but will receive,

1st sentence '.. staff will be required…' the in bullets this is dropped to 'expected'

49. If not, do you have a preferred policy approach in respect of Level 3 of the Being Open Framework for Staff? Please provide evidence to support alternative policy proposals.

Level 3 – Organisations (paragraphs 5.32 – 5.33)

50. Do you agree with the policy proposals at Level 3 of the Being Open Framework for Organisations? If yes, please outline your reasoning.

Agreed in principle.

I have made comment elsewhere on the 'apology' issue

Definition of 'timely' needs to be tied down but needs to be realistic and achievable., The worst way to start any investigative process is by having to apologise for not being ready to proceed within the published & presumably statutory time-frame.

It creates or reinforces the impression that there is something to hide – which would be ironic in the context of a statutory *DUTY OF CANDOUR AND BEING OPEN*.

Agreeing a form of words which meet the concerns raised in footnote 42 on page 84 will be difficult if not impossible.

51. If not, do you have a preferred policy approach in respect of Level 3 of the Being Open Framework for Organisations? Please provide evidence to support alternative policy proposals.

It might seem counterintuitive but why continue to jump through hoops to separate liability & protection issues in respect of apologies?

Courts tend to consider compensation in the form of monetary awards only.

For things like criminal injuries, motor or other accident claims under insurance policies etc there is I believe a 'price list' for claims which is used by the courts. Even the Ombudsman's office probably has a similar menu.

I do not know what the total annual compensation bill is for HSC – and by that I mean not just any monetary awards in compensation & legal costs but also admin staff costs for say running Complaints Dept, costs for diversion of scarce professional medical/clinical/AHP /social work or care time from 'frontline services' , increased on-going costs for the social care /benefits system etc.

My instinct says that, in the majority of cases, what people really want is 'the truth, the whole truth & nothing but the truth and pretty damned quickly' as to what happened, why & how it was going to be prevented from recurring. There is certainly no interest in dragging out issues & allowing them to fester.

If I am right then pure monetary considerations will not apply to this majority. A functioning Candour & Openness policy will 'close out' many of the issues giving rise to such cases.

'Free at the point of delivery' means in any case that the HSC also picks up the on-going costs of any treatment needed to ameliorate the impacts of mistakes or accidents and that the benefits system picks up other costs.

An apology and perhaps a relatively token financial gesture – might be the most efficient & (cost) effective option of closing out the remaining cases in this category.

There will however be other cases – Serious Harm or Prolonged Psychological Harm in the context here – where consequential financial damage will drive the legal/compensation process. Even here there might be innovative ways of settling/

reducing costs of claims. Perhaps an apology and an offer to pay for an element of private hospital care in order to speed up recovery & recuperation might be appropriate. If *Candour & Being Open* works this may make assessing liability less of a contentious issue.

Probably a weak analogy but if you have a car off the road due to an accident the use of a courtesy car to get you back on the road whilst repairs are carried out is part of the insurance cover. I really cannot see why something similar would not work in HSC cases – particularly high risk/impact ones.

Additional Feedback

52. Is there any additional feedback that you wish to provide in respect of the policy proposals for the Being Open Framework? If so, please provide evidence to support alternative proposals, if possible.

I wish to repeat points made earlier:

there seems to be a heavy medical/clinical bias running through the document

that Health & Social Care are different but need to be treated equitably in the Candour & Openness framework

that there is a negativity bias in the document with emphasis on things going wrong & consequences thereof

that there is an opportunity for a positive approach to learning & development & service improvement & innovation but it is essentially lost

(as indicated above I would accept that the notion of 'taking the learning' has over long periods become discredited by being used as a smokescreen for avoiding organisational & personal liability for errors/mistakes)

Organisations & individuals may have concerns about the impact of a Duty of Candour & Being Open.

There is nothing new or unusual about it. I have suggested above that virtually all HSC staff will have experienced a version of Candour & Being Open in practice.

Anyone who has bought a mortgage, loan, credit card, pension, investment or insurance product any time in the last 30+ years will done so only after going through the process of fact find /financial health check & after receiving copious factsheets, product information leaflets etc.

The principles behind *Duty of Candour & Being Open* is precisely the same only involving physical & mental & social need health checks- just 40+ years late!.

Consultation & Impact Screening (Section 6)

53. Do you have any feedback or data which may be relevant to the potential impact of the policy proposals within this consultation exercise, in particular in relation to the following areas:

- Equality;
- Human Rights;
- Rural Needs;
- Regulatory; and
- Economic Impact?

54. Do you have any feedback in respect of the potential indicators that could be used in order to measure the effectiveness of this policy?

Its going to be down to qualitative surveys rather than quantitative indicators largely

I'm guessing that no-one will want to formally 'record' the number of staff/patient 'candour & openness' encounters – why would you if it is routine?

The only things I can think of would be the numbers of complaints received Paradoxically there may be an increase in numbers received so key metrics would be unresolved cases

You may see across the system less bed time/consultation time if people better understand their conditions & treatment

There may be less expenditure on meds/kit if become more committed to finishing courses of treatment rather than opting opt part way through because 'they feel better' rather than are better & then having to repeat the process

55. Do you have any feedback or suggestions on how best to engage and involve stakeholders on the development and implementation of this policy going forward?

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'A Study to Investigate the Barriers to Learning from Serious Case Reviews and Identify ways of Overcoming These Barriers' by Rawlings, Paliokosta, Maisey, Johnson, Capstick & Jones.

Kingston University - Institute for Child- Centered Interprofessional Practice (ICCIP)

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