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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: **IHRD.implementation@health-ni.gov.uk**

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.

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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.

I do however feel that perhaps 'proactive' openness is necessary so that Health & Social Care staff have the responsibility to notify service users, patients and their families of failings rather than waiting for people to ask the right question which sometimes people are reluctant to do or 'don't know what they don't know'!

Information and communication on what can be expected in any situation whether health or social care is of paramount importance.

It should not be underestimated the cultural overhaul required to deliver 'openness' within the present system.

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.

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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.

Yes.

Every organization mentioned.

I would also ask you to reference the review of Leadership and Governance at Muckamore Abbey Hospital where it was demonstrated how a lack of honesty, transparency, and accountability has led to the alleged abuse of vulnerable adults.

https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-mah-review.pdf

Organisations including the arms length bodies like RQIA and PCC failed families and service users.

The delay in implementing this Duty of Candour in Northern Ireland has caused more unnecessary harm to patients and their families.

There is a lack of clear accountability across the whole Health and Social Care system within Northern Ireland.

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.

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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

From the 2009 NI Reform of Health & Social Care Act (section 20) it is a statutory duty to involve service users and their families in the planning and delivery of any changes to services and policies. It could be argued that if this statutory duty was being upheld that a duty of Candour would be second nature to most professionals within the health and social care system. But unfortunately this is not the case and monitoring how these statutory duties are being implemented is the only way forward. Who audits such systems is also key so that the public can have confidence restored in the Health and Social Care system.

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.

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.

Yes

What happens in instances where people with no capacity cannot communicate the harm being done to them? How do we make sure they are safe from institutionalized abuse and not dependent on the integrity of health care professionals?

The incidents at Muckamore have left real fear in families with learning disabled adults that the system can have had its moral compass skewed and no one is prepared to speak up.

Primary responsibility should be the delivery of safe care to patients and service users but there is more loyalty in health and social care at protecting the system and individual employees themselves.

It was only with CCTV and staff being unaware that it was running that the incidents of abuse were recorded and documented. Family queries and complaints were ignored. Access to patients and their rooms were restricted. Reports by in reach workers on resettlement plans disregarded.

Although incidents of abuse suddenly disappeared when staff knew that cctv was running, this seems to be hardly credible. The values of staff are very important when working with learning disabled people and I would not be convinced still that all staff share these values.

I am hoping that the practice of candour will restore my faith in the system and instill different behaviours in staff. I am not sure.

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.

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.

Yes

I also believe the written report of what has happened should be corroborated by the service user and their family so that facts gathered by professionals are correct and agreed with additional information added if needed.

It is important that families and service users/patients understand the corrective actions being taken as a result of the incident? How will the information/learning be distributed to the rest of the organization to make sure such incidents do not happen again?

Full inclusion of the family/service user/patient or independent advocate in any review of the facts is necessary.

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.

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.

Yes I would like an apology legislated for. I have never heard frontline staff say they are sorry for anything as if it implicates failure or fault and it is not part of normal behaviour. All staff should be expected to do this so it should be laid out exactly in legislation to make sure it happens.

Families will know instantly if the apology is genuine by the tone and language used, the way relevant information is communicated, how quickly questions are answered, prompt actions taken to improve the situation, ringing people back, clear ownership of the issue. This is about building confidence and trust with the people involved. It will be behaviours that speak louder than words.

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.

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.

Yes. Key leaders being available and involved will be a clear signal to other staff of the seriousness of the situation and the expectations in behaviour. Debriefing staff, being visible throughout, listening to their feedback will be showing the importance of the incident to everyone involve.

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.

<u>Support and protection for staff (paragraphs 3.27 – 3.28)</u>

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.

Yes

My reservations are that not all leaders have the skills to create the kind of culture needed. Communication and listening skills are not prioritized and the valuable experiences of frontline staff are often missed.

The structure of Multi disciplinary teams is in many cases lacking the leadership and a key point of contact with service users/patients and their families to deliver accountability.

Collective leadership in principle is a good idea but in practice there are still too many individual professional silos and competition which is not creating cohesive teams with aligned outcomes for service users and patients and their families.

There is an inherent fear of families and their inclusion in anything so work on these relationships is vital.

Building confidence in staff to work closely with families can be a major lever in achieving the duty of candour but more importantly developing services which deliver improved safety and quality.

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.

Give frontline staff a chance to understand what this will mean in their daily work. Encourage building relationships with families and service users/patients and including them in care plans, risk assessments and other issues that are important to them in the delivery of safe, quality and compassionate care.

Create time to work on staff ideas for improvements….create a collective ownership of the service.

Strengthen the whistleblowing policy so that staff can be protected to highlight when organizational practice is leading to care being unsafe.

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

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.

It will only be in providing evidence gathered from patients/service users, their families and front line workers that effective monitoring can be achieved. Mechanisms by which this information can be gathered is important. It should be available in the public domain so that we can measure the effective implementation and provide the challenge needed on progress. Internal monitoring by DoH and RQIA is not adequate. There needs to be public accountability.

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.

Yes We are in great need as a society to see some visible accountability within our health and social care system for the many failings and cover ups that have occurred over many years. I do not see the personal integrity in some professionals that I would expect in many positions of leadership.

We need to see people held accountable for their action or inaction and removed (sacked) from their positions. Not moved or promoted to other positions or allowed to retire before proper investigations have taken place.

In many cases it is taking far too long before action is taken, and this is having a detrimental impact on our whole health and social care system.

There is an urgent need to try to reestablish public confidence and trust in the health and social care system. Damage to the most vulnerable people in our society is an indictment of the system and only poses the question 'if it is happening within statutory services, where else is it happening?'

Professionals who tell the truth have nothing to fear from this duty of candour but I am concerned that the present culture does not welcome challenge and hierarchical structures make intimidation and fear a central part of the work environment. This type of culture potentially nurtures poor practice which makes care unsafe.

I have noticed that when meeting frontline people within statutory services, they would tell you their 'band' position before they gave their names. I am not sure whether people believe their positions are not really of much value, they have no real responsibility or their ability to make decisions at a particular 'banding' makes them irrelevant. This is wrong and every person should feel valued and respected at every level. This is the source of the ongoing cultural problem and leadership have not achieved huge movement in this. Encouraging collective leadership at all levels means managers listening and sharing decision making with frontline workers. Effective two-way communication is key. Frontline workers are also those who are closest to their patients/service users and families and have a rich source of information that can positively impact safe, quality and compassionate care.

Most people I know would have a high level of respect for the work carried out by our health and social care staff and are grateful to have them. We understand that mistakes can happen but hiding these facts, telling lies or protecting others whose behaviour is causing harm to patients and service users, especially those who cannot speak for themselves is despicable. There is zero tolerance for this within our society and we need to know it has stopped.

The active involvement of families and service users in the services continues to be a missed opportunity to deliver safe, quality and compassionate care.

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.

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, but would like to see people sacked not just fined. Who would want to work for or with such people? How can you trust such people again? What impact would this have on the organization? This kind of behaviour needs to be eliminated from the organisation. I know in the business sector that claiming inappropriate expenses on a travel expense report will result in termination. In these instances of protecting people or telling lies with regard to incidents that have happened to patients and service users which have resulted in harm, trauma or death are considerably worse.

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.

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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 think the content of the Leadership & Governance Review of Muckamore Abbey hospital should be considered as evidence in pursuing a duty of candour.

https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-mah-review.pdf

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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 agree with a statutory individual duty of candour with criminal sanction.

I agree with Justice O'Hara's view that existing oversight mechanisms within health and social care have not been sufficient to ensure that candour takes place.

Not sure I agree with an arm's length body of the department of health like RQIA carrying responsibility for monitoring breach of duty of candour. Should be someone independent of Health & Social Care system.

What protection do employees have if obstructions to duty of candour come from managers or leaders?

The values and behaviours of leadership are key to successful implementation of a duty of candour and where potentially the greatest weaknesses are presently visible within the system.

In the situation of alleged abuse at Muckamore Abbey Hospital the recommendations of the Leadership & Governance review have not been implemented. It is obvious dysfunctional leadership has had a significant impact on what happened and yet there is no transparency in what changes have been made as a result of this learning.

https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-mah-review.pdf

Ideally there should be regular opportunities for staff to give feedback and ideas for improvements– this should be facilitated and welcomed by management to feed into a continuous improvement and open culture.

Alternative Policy Proposals (paragraphs 4.23 – 4.35)

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

I do not agree with proposal a or b

I am hoping that the main outcome of the duty of candour is that a more transparent and stronger health and social care system with patients, service users and their families at the centre.

If telling the truth is not a compulsion for professionals, with real consequences if they are not honest, then we are not going to see the change that we need.

People may be sacked but still take up a position within another part of the system whether the independent sector or community and voluntary. With a criminal prosecution we protect our most vulnerable and keep these people out of delivering health and social care in other similar environments.

Individual professionals and other employees can start demanding from leadership the resources they need to meet the demands of their jobs and contribute more actively to the agenda of delivering safe, quality and compassionate care.

This is the key to promoting real collective leadership and collective accountability.

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.

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.

Everyone working within the health and social care system (statutory and non-statutory) should be held to account on an individual duty of candour with criminal sanctions for breach).

Honest and open information should be made available to the public with respect to many processes and policies. Social care is another very key area where many service users and families feel excluded from decision making processes on assessments, care plans, risk assessments, safeguarding and service planning.

Effective communication is a very integral part of a duty of candour and needs developed in many leaders. Internal communication with employees is as important as external and in many cases, this is lacking.

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.

Yes. I see this as basic requirement of the job. I think honesty and integrity are values which should be a pre-requisite for employment and should be part of the interview process.

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.

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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 am not sure what the exemptions would be. I worry that it could be a slippery slope and defeat the purpose if we start making exemptions.

There are many good professionals within the health and social care system but there are others like in many other walks of life who are arrogant, self-serving and lack the personal integrity which these jobs require. There are people in leadership positions who are not leaders and that is dangerous in a health and social care system where many people will be influenced by these behaviours.

The 'talk' of HSC values is not being 'walked' by many in leadership positions. The needed changes in culture have not occurred on the scale required and the system is still being served above the patient/service user and their families.

The training on values and associated behaviours has not been cascaded across the system.

We would not be at this point if there had not been very serious failings in this system and it is incumbent now that the public has the biggest influence in creating real change.

For me a duty of candour means accountability and we desperately need to see this.

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.

Mr Justice O'Hara said 'The unfortunate truth to be drawn from this inquiry is that there are too many people in the Health Service who place reputation before honesty and avoidance of blame before duty. All that is required is people be told honestly what has happened and a legally enforceable duty of candour for individuals will not threaten those whose conduct is appropriate.'

I have reviewed responses from several of the professional bodies and agree with Mr Justice O'Hara that it is not sufficient to have the 'ethical duty' of honesty that is

placed on them by their professional bodies. The evidence revealed at the IHRD inquiry clearly shows a weakness in ethical duty.

The public cannot wait until the end of a public inquiry at Muckamore Abbey Hospital to reveal the same.

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.

Yes.

In many instances beginning with good internal communication will facilitate frontline staff in communicating in an informed way to families, service users and carers. Having a feedback loop from the frontline to management and back will make sure that all can speak with confidence and staff are supported with any arising issues.

Encouraging good personal and public involvement of families and carers throughout all levels of the organization will embed respect and capture the knowledge that families have of their loved ones and ensure care is as safe and compassionate as it can be.

Working in partnership can build the trust needed and develop better solutions for service users and patients. Acknowledging the mutual fear at times of families bringing a concern about care and the defensiveness of professionals who will not admit that care could be better is the first step in building partnership.

In many instances families need information to understand how the health and social care system works so they can contribute. This is not always forth coming and many people don't know what they don't know.

There are potentially gaps in the knowledge of the professionals tasked with implementing policies e.g., safeguarding and restrictive practices and this needs to be addressed by leadership.

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.

Yes. Families and or independent advocates are essential to making sure that service users with lack of capacity and or communication difficulties have their rights upheld. Having families as an integral part of the MDT can ensure these service users and patients receive safe, quality and compassionate care by being part of the decision-making processes. Professionals making reasonable adjustments and including those with expertise (families) will improve outcomes for individuals. There continues to be, no matter which review it is written in, inquiry recommendations made, an issue in implementing real change in our health and social care system. It is questionable how individual Trusts take well written policies, interpret them and implement them. There are many inconsistencies across the region and frameworks can sometimes leave service users and families dismayed as there is no real compulsion for anyone to follow. I am reminded of this comment by Richard Pengelly after the Margaret Flynn SAI Review on Muckamore 'A Way to Go' *"I remain very concerned about the HSC system's current structures and attitudes regarding concerns and complaints from service users and their families. All too often, it seems the onus is on citizens to persuade the system that something is wrong."* Richard Pengelly, Permanent Secretary, Department of Health at a meeting with the families of people at Muckamore Abbey Hospital, 17 December 2018 and re-stated in evidence to the Northern Ireland Affairs Committee on 16 January 2019.

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.

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.

Yes

The cultural changes needed must be obvious from the top down in the organization. Middle managers especially need to be chosen for their ability to communicate effectively and have strong abilities to listen and engage with their staff. Giving feedback to staff and receiving their feedback in an open way will encourage a new way of working.

Leading by example of what is required by the duty of candour will be the most effective way of embedding the practice. Laying out clear expectations of behaviour towards patients and families and supporting staff in these changes will be important. Looking for evidence of how families and service users are involved and included in care plans, behavioural support plans, risk assessments, safeguarding incidents will be a measure of how practices are being followed.

Reflective practice is an essential part of the work environment and how it contributes to improvements. Feedback is important for every employee – praise and improvement opportunities.

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.

Yes

I would add that actively working with complaints to form the quality improvement agenda is essential. Transparency in types of complaints, SAIs, SEAs, safeguarding issues, use of restrictive practices is important for employees to see and understand.

Look for evidence of PPI.

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.

Yes

As mentioned, PPI needs to be properly embedded across all parts of the Health & Social Care system whether it is in new policy development and implementation, changes in service or quality improvement. It is not just relating experiences but part of developing solutions and the decision-making processes.

This has been a statutory duty since 2009 but has not been embedded in practice. I hope things can change but unless attitudes towards families and service user involvement changes this will remain a barrier to the 'Being Open Framework'

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.

Yes. But believe there may be difficulties in getting staff to report mistakes of others. This takes courage but fundamentally if staff understand that their first duty is to the service of the patient or service user then it should make it easier. I do not believe the system emphasizes this enough and protection of the system is always more important. This needs to be addressed.

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.

Yes It however needs to be made clear by the organization that all service users and patients and their families are equally important no matter who or where they are and acknowledgement that what happened at Muckamore was partially due to the attitudes of the organization towards learning disabled people: being viewed as not as important as everyone else. It would be very important to address the training needs of staff even before a duty of candour is instigated as there are immediate deficits that need addressed.

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.

Yes

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.

Yes. In some cases, decisions and actions by line managers impact directly on the performance of front-line workers. Line managers who do not taking staff training or safe staffing levels seriously, are equally accountable. Policies like the use of restrictive practices need careful consideration on implementation as staffing skills on positive behavioural support are necessary as a

first line of action. This is not the case today and places like Muckamore Abbey Hospital and Lakeview Hospital where staff need this training need to be properly resourced and trained.

Many of the issues highlighted in the Leadership & Governance Review of Muckamore point to a dysfunctional leadership model that has not supported front line workers.

How these managers are held to account is a critical element of the duty of candour in their support of front-line staff.

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.

Yes

Communication ability is key here.

Independent advocacy is presently not widely available and needs to be developed for families and service users.

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.

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.

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?

In many instances the Public will use the complaint system as a last resource so getting feedback directly from this cohort on their experiences with health professionals will help to monitor change and the continued barriers to any duty of candour implementation.

It must be more transparent to the public the categories/details of complaints, root causes, how they are being handled and how learning is distributed across all systems within Northern Ireland. These are the things that should be driving the quality improvement agenda for the Health & Social Care system in Northern Ireland.

The complaint system should be viewed by every member of staff as a way to improve the quality and safety of care. It is not proactively being used as a tool for continuous improvement.

Make sure that a focus on information on relevant processes within each programme of care and area of service are available to the public. What are the commitments to the public? What can they expect?

Independent measuring/auditing of all policy implementation by Trusts to make sure they are doing what has been laid down.

Measure the use of reflective practice within multidisciplinary teams to develop collective responsibility as well as collective leadership.

I would also look at the number of judicial reviews being taken by individuals and the reasons.

Maybe a register within the complaint system (revised forms) where service users/patients and families can indicate specifically where they feel a duty of candour has been absent.

The details of SAIs, SEAs, safeguarding incidents (adult protection) which should include families would be a good source of feedback on experiences of candour from professionals.

The PPI activity across statutory services with regards involvement on individuals and the public would also be another area to monitor and get feedback. To be involved includes sharing information on data, processes and policies with participants. This would be a very useful way to reflect how behaviourial changes are actually being embedded in the system.

I would recommend that there is some independent review/audit body outside Health & Social Care to monitor implementation across each area of Health & Social Care system of the duty of candour.

As it was recently written in an article from Nick Garbutt (Scope NI), 'when medical staff make mistakes in treatment it is imperative that they are faced up to and that the families of those affected are told. This principle is so fundamental to the proper working of our health service that it seems remarkable that it is even a matter for debate'.

I couldn't agree more with this statement. I believe that many people have felt desperately let down by the behaviours of health and social care professionals and we need to see radical change quickly if confidence and trust are to be restored and the transformation of our health and social care system can happen. The procrastination and delay in implementing Mr Justice O'Hara's recommendations has potentially been the root cause of continued scandals and failures within the system and more costly public inquiries being commissioned to get to the truth.

It is a shameful state of affairs and an indictment on our health and social care system that recommendations from reviews and inquiries are left until mandated to be implemented.

There is no longer time to develop a different culture or expect people to do the right thing and this is why it must now be imposed. If you work in the Health & Social Care System, then you need to tell the truth or accept the consequences.

The Public has placed a huge amount of trust and faith in the Health & Social care organisations/systems but they also have expectations and many of the individuals in it have let us down badly. It is not adequate anymore to expect professionals to do the right thing and that is why we are where we are. The practice of protecting

and serving the system/organisation before the patient/service user and their families, needs eradicated.

I would also draw your attention to the fact that a few health and social care professionals (three retired and one in top management) did not speak to the team reviewing the Leadership & Governance at Muckamore Abbey Hospital.

This was another slap in the face for the families of abused service users at Muckamore, and those in the community who have family members who have learning disabilities. How little do their lives mean? What further disrespect can professionals display to service users and their families? They should be ashamed to call themselves 'professionals'.

There has been no one in the leadership structure of the Health & Social Care system that has been held accountable for what happened at Muckamore.

The system continues to protect and serve itself first and foremost.

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?

There needs to be a comprehensive communication strategy on this and extensive training for HSC leadership on the expectations and practices required. It will fail if they do not lead effectively.

Do all employees understand the HSC values and the expectations on behaviours that reflect these?

Do employees understand that the safety of the patient/service user is their first priority and they have a duty to speak up if this is being compromised? Do they have leaders who lead by example and reflect the values and behaviours?

Are people welcomed to challenge the system, listened to on improvement ideas, involved in understanding the issues and developing solutions?

The public needs to have a mechanism by which they can hold the system to account on this policy. Failure to implement effective PPI makes it all the harder to see how any new statutory duty of candour can be implemented and maybe there should be an honest discussion within the system about these failings to understand how things can be done differently. What are the barriers and why does it take such a long time to change anything?