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NIPSA Response to Duty of Candour and Being Open Public Consultation

August 2021

1. Introduction

1.1 The Northern Ireland Public Service Alliance (NIPSA), as the largest public sector trade union in Northern Ireland, recognises the importance and is pleased to respond on the public consultation ***"Duty of Candour & Being Open – Policy Proposals".*** NIPSA as an organisation and trade union would have in the region of 9000 members working across the Health and Social Care system – this response is based on Branch discussions and feedback submitted centrally.

We wish to state early that **NIPSA cannot agree to any policy** that introduces a criminal liability on our members.

2. General Comments on Consultation Paper

2.1 It is important to be clear at the start of our response that based on the feedback we received from members in a range of settings and disciplines, NIPSA supports the principles of a *Statutory Duty of Candour* to be applied across the Health and Social Care system to deal with scenarios when care or interventions go wrong.

2.2 As the public are constantly told, the HSC is a system, and it is NIPSA's view that the vast majority of failures of care that individuals experience is due to system failure - which is why NIPSA supports the foundational importance of a *Statutory Duty of Candour* across the HSC system. NIPSA believes lapses in care/errors and mistakes in whatever setting represent key learning opportunities/moments to reflect on practice so that the system as a whole can learn from the mistakes and errors of individuals and services and of course organisations.

For a whole range of reasons, this has shamefully not been the approach that cohorts of families have experienced within the HSC when something of significance has gone wrong. Defensiveness, cover ups and abdications of responsibility by individuals and systems, such as those highlighted by Justice O Hara, happen in organisations and is the lived of experience of many families over many years. Furthermore, the culture of patient safety, excellence in service delivery and openness with both staff and service users can become fatally compromised by toxic stews with corporate protection, fear, and cronyism as the key ingredients.

Cultures of blame, fear and self-protection grow directly as a response to the leadership of any system. In the HSC, leaders set the culture for others across departments, in services, within HSC Trusts, at the HSCB and at the DOH. The fact that this consultation is being held says much about the current key leadership of the HSC. These approaches in no way are representative of the key values underpinning the health system in Northern Ireland.

2.3 Those who own responsibility for the culture that Justice O'Hara's recommendations are trying to address, have through both their actions and inaction much to answer for. But, as ever they are content to deflect the key

responsibilities they have down the line. They ignore the foundational role that their approach of promoting excellence out of one side of their mouths while leaving over worked practitioners across all disciplines struggling to deliver care. This is reflective in all the current scandals that have led to this consultation.

2.4 In NIPSA's view none of the scenarios or issues that have led to this moment are new. Whether it's the well understood risks of single consultants operating without peers or challenge in cash starved over worked and inadequate services, or the shortcomings and ultimate failures of the practice responsibility and accountability mechanisms that were so crucial to the Hyponatraemia scandal. Or the unacceptable damage done to families simply seeking the truth about the care delivered to their loved ones by by the policies and litigation systems that the DOH itself is responsible for and is clearly borne out in Justice O'Hara's report.

2.5 The implementation of a *Statutory Duty of Candour* at all and every level of the HSC is needed and will be unequivocally welcomed by NIPSA. But it will not of itself correct the problems above.

2.6 As a trade union, NIPSA's view is that the implementation of an *individual criminal sanction* to underpin this duty is wrong and as an organisation we are opposed to the *individual criminal sanction* approach within this consultation. This both from a principled *trade union* perspective, but also crucially from a settled view that it is an attempt to deflect the rightful anger that people feel at the state of our Health Services away from those responsible for the mess that many services and settings have historically and currently experience.

As a representative body for members across the HSC, we recognise there are challenges for trade unions in the protection of members and in campaigning for the provision and maintenance of quality services that are staffed safely and appropriately and able to provide the high quality of service the public expects and which our members wish to deliver.

2.7 It is our members view that the *individual criminal sanction* approach will hinder, not help, in the quest to truly embed cultures of openness, transparency and learning across the HSC. A *Statutory Duty of Candour* in relation to the consequences of the current approach to financial management and workforce planning would however be foundational.

Openness on what these financial and workforce approaches mean in practice alongside accountability for those taking these decisions is in NIPSA's view needed to meet this consultations ambitions.

High risk service approaches, a confrontational litigation system and mistakes made by over stretched workers are not best addressed by the *individual criminal sanction* approach in this consultation. Embedding **Responsibility** and **Transparency** at the top will do more to address and change the key drivers of the culture of blame and fear, which plays the central role in all too many of the

scandals that have emerged across the HSC system over the last number of years.

Individuals, particularly registered professionals, are of course accountable for their practice errors in care. NIPSA believes that there are a range of approaches, not all adequately developed in this consultation, that could better protect the public, improve services and deal with poor practice.

2.8 NIPSA has no truck for cover ups, cosy professional relations, or any reluctance to embrace truth and transparency for families by individuals or organisations. It is NIPSA's view that the role of those involved in any daisy chain of events, actions and learning for any incident where serious harm or death occurs must fully co-operate with any subsequent investigation(s) that is attempting to get to the truth of what happened.

It is only by doing this that proper learning can be taken from any such scenario so that actions can be put in place to try and ensure that such situations do not occur again.

2.9 As outlined, this consultation is taking place within the context of, but not exclusively, recent high-profile failures within Health and Social Care (HSC) such as Hyponatraemia Inquiry, clear issues around the work of Dr Michael Watt, Neurology Consultant, and more recently the adult safeguarding issues in relation to the alleged abuse of patients at Muckamore Abbey Hospital.

In relation to these and other issues, NIPSA fully supports the right of individuals and families to get to the truth of what happened to their loved ones. In the case of the Hyponatraemia enquiry, the role of both organisations and key professionals in getting to the truth and as outlined by Justice O'Hara, fell far short of what the public and those families expected. Hence the reason why as an organisation we support and recognise the need to for a *Statutory Duty of Candour* across the HSC.

2.10 It is reasonable to say that the issues above, and the subsequent media and public concern for the welfare of patients/service users etc and failures of governance, have significantly eroded public confidence when something does go wrong. While investigations and announcements of public enquiries in relation to two of these issues has recognised the seriousness of failure from HSC Trust's, the further public perception is of a HSC system set up to protect itself, with families unable to get to the truth of what happened to their loved ones when *"serious harm"* or *"death"* occurs. Furthermore, the absence of key individuals in getting to the truth, frustrates this process and casts doubt on the legitimacy of any such process to get to the truth.

NIPSA believes that existing legislation already sets out key powers linked to an individuals failure to engage in, fact or in spirit, with properly constituted enquiries. It is our view that much of the frustration felt by families and those charged with arriving at truth is due to the role of the Department of Health and its legal advisors in constituting and drawing up the terms of reference for

enquiries in ways that mean well established precedents, related to cooperation, giving evidence etc., are not routinely able to be applied.

2.11 NIPSA therefore recommends that the Northern Ireland Assembly take the necessary actions to ensure that current public enquiry legislation can be applied more consistently in matters that have caused death or serious harm to citizens in whatever part of the Health Service. Such an administrative approach makes the establishment of a new criminal sanction linked to the duty of candour moot in our view.

2.12 As stated, within the context of this consultation, NIPSA consulted with members across and beyond the HSC. Many of those NIPSA consulted with, would have direct experience in adult safeguarding and child protection, as well as direct care for patients in hospitals. NIPSA's response therefore is taken from this cohort of membership at different levels of responsibility for the direct provision of care in the HSC.

3. Current HSC Pressures

3.1 This consultation arrives at a time when HSC services across Northern Ireland are experiencing unprecedented pressures. This is due to a combination of factors such as the response to the Covid-19 pandemic, shortages of key skilled staff i.e., consultants, Nurses and Social Work etc, and at a time when waiting lists and waiting times have never been longer.

3.2 Key proposals on restructuring our Health Service are also at various stages of implementation and consultation, with much more to come under the Bengoa proposals. Combined, this has meant the current pressures have never seen HSC services in a more vulnerable place with regard to delivering key services whether in an acute or community setting.

It is because of this that some questioned the requirement to have a *Statutory Duty of Candour* and believed it was another attempt by those who should be accountable for the mess that many services are in to avoid taking responsibility for their actions. Within the context of this consultation NIPSA believes Responsibility and Accountability are the conjoined twins of transparency. With this in mind, the proposals being consulted upon are in NIPSA's view inadequate in establishing a *Statutory Duty of Candour* for the failures of the strategy setters and budget managers who continue to be accountable but not responsible for the systems breakdowns across the HSC. They are the hidden manifestations of why there needs to be a far-reaching *Statutory Duty of Candour*, as the concern is that with these ongoing huge pressures mistakes that impact on patient care or service provision are more likely to be made now than ever before.

4. Structure of Consultation

4.1 Many NIPSA members raised the issue of how this consultation is presented. Many felt the questions and content of the paper took a very medicalised

approach and view of services and often referred to clients as patients and receiving care as opposed to being considered, for want of a better term, as services users or receiving a service (or services).

4.2 There were also strong feelings of a *one size fits all* approach in how this consultation is presented, with no indication of context of how various services operate and how decisions are made. Within the confines of this consultation, members felt there is no recognition of the fundamental differences in how a medical model of care works against how a social care model works across the HSC. An integrated system demands a fit for purpose single approach to this key topic and in the view of NIPSA and our members the proposals being consulted upon fall fundamentally short of the mark in this regard. Doctor does not always know best.

NIPSA's members in social care services wanted to highlight that key aspects in the decision-making pathways they operate are characterised by range of factors defined by uncertainty and balance such as historical context, risk management, capacity, and social factors within a family. These are fundamentally different from the diagnostic pathways and environment that our medical colleagues practice within. The consultation proposals do not recognise this reality.

4.3 Professionals in the social care arena often have to rely on accessing antiquated IT systems not helpful in collating important data in any constructive way that would inform risk assessments and services. This is not an excuse for poor practice or poor interventions, but was a challenge for NIPSA within the context of responding to this consultation.

For instance, NIPSA members may work in the area of child protection, where plans need to be prescriptive in order to safeguard the welfare of (a) child(ren). Whilst plans can be constructed with the agreement of parents/young people/children, the nature of the service means that as a HSC organisation there may well be elements of proposed services where individuals are not necessarily in agreement, but the expectation is they must to be implemented to protect the vulnerable.

This would also cut across adult safeguarding scenarios and those with a learning disability or with mental health issues. All interventions to protect the vulnerable in these scenarios carry the risk of significant harm. For example, the life indicators for the care experienced population of the HSC are poor. This population, research shows, have hugely elevated risks of drug use, self-harm, and likelihood of being caught up in the criminal justice system. But these potential significant harms inform the basis of assessment in, for instance, child protection case conference where professional groups need to make decisions to protect a child from actual or potential harm in the here and now.

4.4 NIPSA members were of a view the consultation paper failed to properly acknowledge these issues due to the said overarching medical model being a dominant feature throughout the consultation document. Indeed, the prevalent view of NIPSA members was that the medical profession could learn a lot from

social care services where a person-centred approach has been firmly established and embedded in services for many years. This is within the context of seeking specific agreement with those requiring social care with the inclusion of advocates and families in the formulation of care plans so that individuals and their families are clear about the support and services required.

4.5 NIPSA members therefore view the proposals as a missed opportunity to put the values of person rather than a system centric care at the core of the HSC going forward.

4.6 Another concern that was raised was the Q&A type response expected throughout this consultation document. Whilst NIPSA acknowledges this may be helpful in the collation of responses, we are not convinced this approach is helpful on a consultation of this nature. We have seen in the past how organisational responses appear to be weighted the same as individual responses (i.e. Adoption and Children Order consultation) and an "in favour" approach taken on issues of crucial importance. Often it is not a case of "Agreeing" or "Disagreeing" with a proposal, but highlighting constructively the strengths, weaknesses and omissions in a proposal which will elicit a better and stronger response. Because of this, there are a number of questions we simply cannot answer but do comment on.

4.7 The document on a number of occasions (e.g., 4.43 on *Statutory Individual Duty of Candour*) refers to the DOH issuing guidance for implementation at some point in the future. Many NIPSA members expressed concern about this as it was unclear what input stakeholders would have in relation to this i.e., was this a standalone document the DOH would introduce. The concern here is something being included in "guidance" which may present as being outside of the remit of this consultation. NIPSA will consider this and may separately seek meetings to discuss this issue.

4.8 NIPSA will also be seeking clarity on the workstreams that are mentioned throughout this consultation document and are key in devising large parts of it. We are particularly interested in the structure of these workstreams, the work they have done to date, and how this was reported back to inform the consultation document. In the view of our members this approach is fatally flawed.

4.9 If the recent debacle of the implementation of the Mental Capacity Act has taught us anything, it is that legislation should follow the working through of practical issues. To do otherwise is both to enable a suite of classic DOH dodges which will aim to channel the intent of this legislation in ways that minimise the corporate and departmental deficits that characterise the vast majority of the poor care scenarios people experience. This is done while shamelessly setting undeliverable goals and milestones for the workforce. This same workforce is too often left in the catch 22 scenario of being expected to deliver quality care with a new raft of proposals and quality assurance policies at a time of an ever-shrinking workforce, inexperience and deliberate delays to recruitment among many other issues.

5 Resources

5.1 Whilst NIPSA has made it clear our support for a *Statutory Duty of Candour*, we must express our deep concern that its introduction will require significant additional resource across organisations, something which the document is completely silent on. NIPSA has raised its concerns, and indeed took industrial action alongside our sister unions, on safe staffing as voted for by our members across the HSC, at a time when they were facing staffing shortages at all levels across organisations. While the HSC response to Covid has been a monumental effort on all fronts, this was to the detriment of other key services across the HSC, the significance of which has not yet been realised, but which will continue to present huge challenges into the future particularly in relation to staffing services appropriately and safely.

5.2 However, the consultation document outlines clear procedural expectations that will likely be time consuming for those staff involved in the outworking's of any process should significant harm or death occur. Often these staff will be at the front line of the services they work in, whether it is a nurse on a ward, a consultant in a hospital or a social worker in the community. There is a very real danger in this document of the setting up of new and significant bureaucratic structures across organisations with no new resource to ensure a *Statutory Duty of Candour* is implemented in the way that upholds the principles of how it is intended. Indeed section 5.26 mentions a *Family Liaison Person* and lists the requisite skills required for such a role. It is NIPSA's view that time must be given to the funding requirements of a *Statutory Duty of Candour* if it is to be implemented in the way that many hope it will be.

5.3 For example, concern was expressed about the capacity of the RQIA to take on the extra inspection and potential prosecutor role as outlined. The organisation would need to be fully funded for this role and for new responsibilities it will have as a result of implementation of a *Statutory Duty of Candour*. There cannot be a detrimental impact with the other statutory functions of the RQIA. This would need to be clearly defined from the outset otherwise the new powers given to the RQIA will just add to the already heavy workload of the RQIA inspectors, impacting on the functional aspect of the legislation.

6 Response to Sections

Section 2 (p6 - 19) Background

6.1 NIPSA would offer the following general comments in response to questions 1 & 2.

We have no issue with the terminology used. Many members just referred to it as Duty of Candour but perhaps including openness would assist people in further understanding what is intended and what underpins the new legislation. We do feel there may be some confusion in relation to how a duty of candour

is used and how it interfaces with such policies as the Whistleblowing policy (which is not mentioned in this document).

6.2 The authors of this report advise that openness is a "continuum; starting with routine openness" (p57). We are raising this within the context of situations within workplaces where there may be significant shortfalls of staff and risk is increased or work cannot be allocated due to a shortage of workers. Workers need proactive protection rather than constantly having to report retrospectively that there were insufficient levels of staff which did or could cause significant harm to service users. These can be predisposing factors workers experience on a daily basis.

6.3 Members also asked why should the duty be on a worker to inform their employer that there are 50% vacancy rates in their team? Surely those accountable for the recruitment policy, workforce planning and statutory delivery of service are not unaware of these facts irrespective of where they exist in an organisation. Again, the decision makers and budget setters are insulated in these proposals from the consequences of the decisions of they take. Where is the *Statutory Duty of Candour* for the care rationing and quality of service decisions they make?

6.4 In relation to theme 4, focus on leadership, there needs to be more openness and honesty around the ability to provide care with the limited resources available. There are many references to "near misses" throughout the document which potentially sets an implication that Candour only occurs when something goes badly wrong. Traditionally NIPSA would have encouraged members to use DATIX to record unsafe staffing levels as the potential for harm, serious or otherwise, was present. Members felt the outworking's of a Duty of Candour needs to include these incidents and needs to ensure that at every opportunity these shortages are highlighted openly to all stakeholders.

Section 3 (p19 - 38) Statutory Organisational Duty of Candour

6.5 NIPSA would offer the following general comments in response to questions 3 to 23.

We believe the organisations listed is appropriate (Q3&4). We believe it is of particular importance that the Department of Health is listed given their key role in the funding of services and the key decisions on policy and operational direction of Health Service. The DOH must not be excluded from this list given their role in key decision making across the HSC.

6.6 On Routine Requirements (p24) we note the document states (P60 Policy Proposals which this section is linked) *"Service users and carers should expect to be partners in their care, participating in decision making about their treatment in as far as they want to be."* As stated elsewhere, social care services developed very clear pathways of partnership working which is not readily acknowledged in this document i.e. person centred planning/care models. There is no need to reinvent the wheel, scaling best practice up and out within properly motivated leadership groups and fit for purpose service

areas is key to ensuring best practice is recognised and implemented across organisations.

6.7 Being open also means access to interpreters and when required the translations of important documents that reflects ethnic backgrounds which is not reflected again in this document and is a major omission. This is also the same for people with learning difficulties or mental health issues. We are then told again (section 3.11) *"Further information on compliance with this element of the statutory organisational Duty will be included within the accompanying guidance to be issued by the DOH".*

6.8 In relation to questions 5 & 6, whilst NIPSA has no issue with the fundamental principles as presented of openness, members did feel that being asked to support something without the guidance being available but being clearly referenced is flawed and is something that is repeated above and throughout this document.

6.9 In relation to questions 7 & 8 on the definition of significant harm threshold NIPSA has no issue with this but would state that if a "notifiable incident" has potentially occurred then there needs to be a clearer definition between moderate harm and serious harm to ensure that the spirit of candour is implemented. We do note the document states that moderate harm has been included in England and Scotland but we are unclear what is meant by "existing patient safety review mechanisms" as a reason as to why it is not included here.

6.10 We have nothing to add in relation to questions 9 & 10 as outlined.

6.11 In relation to questions 11 & 12 we do understand that an apology may seem "formulaic", but we do not see any alternative in relation to this as part of an overarching response. Assurances in relation to learning and actions in preventing any further reoccurrence of when something has went wrong are, in NIPSA's opinion, of critical importance and greater weight must be given to how these assurances can be implemented with the potential for a follow-up response on how learning and gaps in services are being addressed. A learning culture where people accept responsibility for their actions and leaders are properly accountable for theirs is in fundamental tension with the culture of blame and fear that the DOH currently presides over in far too many areas.

6.12 On questions 13 & 14 NIPSA would like greater clarity on what level is deemed an "appropriate member of the organisation" – senior manager, Co-Director or Director level or even in relation to death etc. Chief Executive. There was a feeling in relation to an Apology that this would be deemed as an admission of guilt or failure and there was concern regarding the comment that this *"would not indemnify organisations or <u>individuals</u> against any liability"*. Members asked how this interfaces with vicarious liability as this is not clear enough in this consultation document.

6.13 On Question 15 & 16, staff support and training is critical both in terms of understanding the principles underpinning a *Statutory Duty of Candour* and in any subsequent investigation when something has gone wrong and staff may

find themselves in a process to understand this. NIPSA members' experience of training on critical issues such as this is not good (i.e., Mental Capacity Act training). Much thought will need to be given to ensuring any proposed training deals with all aspects of a *Statutory Duty of Candour* both at organisational level and individually. Support is also another critical area and it would be NIPSA's view that trade unions must be involved in the development and quality assurance of both training and support for staff and in relation to any strategy to raise awareness. Organisational support has often been seen as lacking for staff when going through a difficult process e.g., disciplinary investigation. This is more so under a *Statutory Duty of Candour* due to the fact that significant harm or death has been a contributory factor which could have significant emotional/mental impact on staff and that anyone who has set out to deliberately harm a service user can already be dealt with under criminal law. NIPSA regards the trade unions having a critical role in this and it would be NIPSA's view that any training and support policy must be approved jointly between the DOH and Staff Side.

6.14 On the issue of reporting and monitoring (Questions 17 & 18), NIPSA agrees that organisations report yearly providing an overview and statistical breakdown on the type of incidents a Statutory Duty of Candour was invoked, by whom and at what level. Members felt this section needed to have an assurance that all relevant information is placed within the public domain and not just the RQIA and DOH as listed. These reports need to be made public and not redacted or edited in a way so as to be different from that sent to the organisations mentioned. Of course, information must be anonymised to ensure individuals are not identified.

6.15 Members however also felt that information also needed to include the number of times and type of situations that a *Statutory Duty of Candour* was considered but not invoked in a service area. This kind of information is important for public confidence and to measure the number of "near misses" the organisation considered as well as the type of situations this was considered. This is crucial in defining the scale of actions needed. By doing this, organisations and relevant stakeholders will be able to identify potential patterns that need to be addressed i.e., administration of medication etc.

6.16 Pages 34 - 38 of this consultation document discusses Criminal Sanctions for Organisations. There is not enough detail to assess or comment on what this means, taking account of para 3.40 (page 37) which if applied makes provisions for individuals to have proceedings brought against them, in addition to the organisation. We would restate that NIPSA are opposed to criminal sanctions. Where an employer needs to sanction a worker there are currently disciplinary policies in place to deal with these matters.

6.17 Members also highlighted the relationship between NISCC and the RQIA and felt key issues in relation to failing services and staff pressures are not recognised between these two organisations. This is despite the two organisations sharing a *'memorandum of understanding'* which is meant to cover and deal with NISCC Codes and Standards of Conduct and Practice for Employers but which has had zero impact. A *Statutory Organisational Duty of*

Candour should be clear about the standard of responsibility employers have in being open about organisational challenges that impact on the quality or performance of services.

6.18 Section 3.36 outlines that it would be an offence not to report in line with the legislative timescales but these timelines have not been established yet (and this is where the legislation will be key). NIPSA would have concerns that these timescales could be inhibited by lack of staffing or access to the necessary systems or equipment and result in a criminal breach due to circumstances beyond the control of the person/work and area/organisation. There are many reasons for unintended delays (staffing and sickness being the most common), so mitigation in relation to delay should be included in this with reasonable timeframes set for completion of reports/investigations etc.

6.19 We note questions 19, 20, 21, 22 and 23 which covers criminal sanctions for organisations. NIPSA has no fixed position on fines for organisations and accepts the pros and cons presented in the paper. NIPSA is of the view that the paper falls short in what action may be taken against organisations that are repeatedly fined under the sections provided at 3.36. A balance must be struck between mitigation and maintaining public confidence and if there is a deliberate attempt by an organisation not to adhere to its commitments under the Organisational Duty of Candour.

6.20 Again, NIPSA must place firmly on record the limited utility of the approach being taken if Integrated Care Partnerships the HSCB and especially the DOH are not fully enmeshed both from a professional and budget setting standpoint in this framework. Ultimately the design and acceptance of delivery models that are intrinsically unsafe is the key factor in most duty of candour scenarios in NIPSA's view.

Section 4 (p39-53) Statutory Individual Duty of Candour

6.21 Please note this section is in response to questions 24, 25, 26, 27, 28, 29, 30 and 31.

Strong views were expressed by NIPSA members in relation to this section, much aligned to that expressed in 4.23 (p46). NIPSA fully accepts Justice O'Hara's views regarding openness and the *"avoidance of blame being placed above honesty and duty".* As stated in our introduction, NIPSA fully supports a *Statutory Individual Duty of Candour* but **NIPSA cannot accept the criminal liability element of this** as proposed by Justice O'Hara**.**

6.22 Over the last number of years NIPSA has seen first-hand chronic staffing shortages across key professional grades especially in nursing and social work. This has led to unmanageable workloads and risk in relation to the management and care of patients, service users and staff. These chronic concerns are well documented by NIPSA in its dealings with the Dept of Health and with employers across the HSC. Whilst efforts remain ongoing to address these massive gaps (i.e., regional recruitment processes and forthcoming safe staffing legislation) it is a continual issue reported to NIPSA of the concern

these staff have that something is going to go wrong. Many of these staff feel vulnerable and unable to speak out for fear of what will happen to them and often use their trade union to raise these issues.

6.23 The impact of covid on the HSC workforce cannot be over stated with many staff working longer hours, working in wards or areas they are unfamiliar with and where they may feel professionally exposed. Many have asked how a *Statutory Individual Duty of Candour* sits in relation to these issues with many feeling the focus of this consultation is not necessarily preventive, but when something has already gone very wrong. Members also stated explicitly that in the past when something has gone wrong, they felt scapegoated and no consideration was given to significant mitigations as they were deemed to be the professional with core responsibility and accountability.

6.24 There was also a level of confusion regarding how the criminal sanction would interface with the many staff who must belong to a regulatory body (i.e., GMC/NISCC/NMC). The feeling was that a criminal sanction for these staff would make little difference as, for example, the NISCC (for social workers and social care workers) codes of conduct and practice openly state registrants to be *"open and honest"* when things go wrong. A breach of the codes is robustly implemented across HSC Trusts with senior staff given the responsibility as to whether a regulator needs to be informed should there be a potential breach. Both NISCC and the NMC have removed staff from the register meaning they cannot practice as a nurse, social worker, or social care worker etc. The likes of NISCC have also for many years highlighted their public protection role which is a central tenet of its function. This is a key DOH responsibility, as Regulatory bodies are almost all in effect NDPB's and it is entirely within the Ministerial role and function to offer direction to these organisations.

6.25 Also, internally within all HSC employers' disciplinary policies and processes can highlight potential breaches of a *Statutory Individual Duty of Candour* and make referrals to the appropriate person as required in the organisation. Many members felt losing their job would be a much bigger sanction than a fine of up to £5000 (as proposed).

6.26 NIPSA's position therefore for HSC staff who must belong to a regulatory body in order to work (i.e., protection of title for social workers) is that there should be a recommendation that all regulators review and where necessary strengthen their codes of practice and conduct in line with the introduction of a *Statutory Individual Duty of Candour*. Such a move would, in essence, work within the spirit and underpin Justice O'Hara's concern on this issue.

6.27 In relation to non-regulated staff, NIPSA is open to a recommendation that employers review their internal disciplinary process again to reflect the introduction and commitment to a *Statutory Individual Duty of Candour*. We also are open about contractual obligations under a *Statutory Individual Duty of Candour* but some members were of the view this needed to be linked more to openness and transparency rather than Candour itself.

6.28 **NIPSA also notes that other jurisdictions have not introduced a criminal sanction for a *Statutory Individual Duty of Candour* after much debate and consideration**. Treating HSC workers in Northern Ireland differently from their counterparts in England, Scotland, and Wales (Similar to the approach taken under the Mental Capacity Act legislation in relation to criminal sanction) has the effect of having HSC staff working to a different and higher threshold to other staff fulfilling the exact same role, job and responsibilities elsewhere across the four UK jurisdictions. This would **be unacceptable** to NIPSA and our members when, as we have outlined, there are mechanisms available to protect the integrity of *Statutory Individual Duty of Candour*.

6.29 In relation to amending staff contracts this was viewed as an unnecessary proposal as all employees are already tied to the policies of the organisation. The key role for employers here is the propagation of the policy requirement of what underpins *Statutory Individual Duty of Candour* and that staff **must** engage as an employee. This must be an issue that is discussed and agreed with trade unions in achieving the assurance that staff realise the implications for them as employees should they not engage or destroy evidence etc when death or serious harm has occurred.

6.30 In relation to points 4.41, NIPSA would be of the view that training and support to staff in reporting a "notifiable incident" is critical. Employers have a role to ensure staff are properly released to attend any training or information days and a clear strategic plan for the implementation of this is required.

Section 5 (p54 - 87) Being Open Framework – Policy Proposals for Being Open Guidance

6.31 Please note – this section is in response to questions 32 – 52.

This section sets a context for openness and embodies learning and development covering a wide range of areas.

6.32 There is little in this section NIPSA members disagreed with although members reported they found the breakdown of three levels for individuals and organisations was perhaps too prescriptive leaving HSC employers' little room to discuss the best approaches to the themes identified with their staff and staff side representatives.

6.33 Members also did feel it listed a rather idealistic scenario where HSC staff have time to undertake, for instance, reflective practice and attend training. While across professional grades both are well embedded, members did state that attending and implementing reflective practice and learning has become more challenging due to the impact of covid and staffing pressures both of which will be significant pressures for the foreseeable future. NIPSA members have stated while these objectives are well established and key to such areas as nursing and social work, they are rarely achievable. This is due to heavy workloads, competing demands, attending emergency situations that arise and unfilled posts among other issues.

6.34 Whilst dealing with the huge demands and responsibilities and staffing shortages is not the remit of this consultation, it nevertheless regularly prevents staff from properly engaging in these basic functions and should be considered accordingly. We are therefore unclear how the implementation of these kind of situations mentioned in this section can in a meaningful way be carried out and how this will be audited in terms of compliance.

6.35 On point 5.18 members wanted to ensure the authors of this report are aware that there would routinely be reviews across services where there were either near misses or indeed where the death of (for instance) a child involved with social services has occurred and a Case Management Review examines social services involvement. This is usually done through the Children's Safeguarding Board and is well established for many years. Information on these cases is usually disseminated to social work staff as a means learning from mistakes and to understanding where there were gaps in the provision of service or where something was omitted or not done to the standard expected. Many NIPSA members were surprised to not see mention of this, given this has been around for some considerable time.

6.36 There was also some concern regarding being open and candid (5.22) following an incident where there may be an investigation or possible legal case. Members felt there could well be conflicting advice from employers to "say nothing" until a legal opinion had been sought. Consideration needs to be given on this issue as this may cause confusion as defensive practice has been a long-time position among a lot of HSC staff where openness can sit uncomfortable.

7 Conclusion

7.1 To conclude. NIPSA recognises and supports the need for a *Statutory Duty of Candour* across organisations and on an individual basis. **We remain resolutely opposed to the proposal to introduce an individual criminal sanction on the basis of the points above.** Indeed, the current proposed approach is proof of the old adage, that ***bad cases make bad law.***

7.2 Other existing organisational, regulatory, and contractual approaches, if combined with real commitments to build out existing good practice and truly embed a just culture approach across the HSC, will deliver better outcomes for service users and workers alike within a learning culture.

7.3 NIPSA, as a trade union and organisation, also gives a commitment to work with the DOH and employers with a view to how best issues of training and staff shortages and implementation of the *Statutory Duty of Candour* can best be achieved.

This concludes NIPSA's response however we reserve the right to return should the need arise and when responses are received to the points and questions we have raised.