Department of Health
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Männystrie O Poustie
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Being Open Framework

Consultation Response Form

RESPONSE FORM (IF NOT RESPONDING ONLINE VIA CITIZEN SPACE) Please indicate your answer to the questions by **circling** your selection. You can also provide further comments in the free text field.

Please send responses electronically using the response sheet below and email address below.

Responses to be sent by email to:

being.open@health-ni.gov.uk

or by post to:

Being Open Team
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Consultation Response Form – Being Open Framework

CONSULTATION QUESTIONS

Please indicate in each section if you agree YES or NO and add comments in the box below.

Understanding Openness and Culture

These questions focus on how organisations can create a culture where being open and honest is the norm (further information is provided in Section 3 of the 'Being Open Framework').

Q1 The framework looks at openness at three levels:

- **Routine openness:** Being honest in everyday care and communication.
- **Learning from mistakes:** Reflecting on errors to improve and avoid repeating them.
- **When things go wrong:** Clear communication and accountability when harm is caused.

Do you think these levels are helpful and appropriate? YES NO

Q2 The framework focuses on three areas of culture in an organisation:

- Infrastructure (e.g., policies and systems to support openness).
- Behaviours (e.g., how staff interact and communicate).
- Beliefs and stories (e.g., shared values and lessons from the past).

Do you think it's helpful to also focus on three areas? YES NO

Comments: There is concern that this newly proposed model / approach will not result in the transformative change that is required. Section 2.2 of the consultation document

refers to legislative duties and guidance under the existing approach relating to an open and learning culture. Sections 2.2.1 – 2.2.3 set out a comprehensive list of the existing components of an open, just and learning culture.

It would appear that there are adequate components in place (on paper at least) to sustain such a culture but either these are insufficient / inadequate, or, there are significant barriers that prevent them from working.

Despite the range of components therefore that have been in place for some time alongside requirements to be open and candid, we continue to see inquiries / reports and recommendations which indicate that this is not the case – eg Muckamore, Dunmurray and Hyponatraemia Related Deaths as well as more recent examples of individual cases as highlighted by the Northern Ireland Public Services Ombudsman (NIPSO) and coroner reports.

The consultation document does not explain why the existing measures are insufficient / inadequate and how and why a new range of measures will shift the dial. Further problem analysis is required that provides a justifiable rationale as to why these existing measures are not achieving the desired effect. This analysis needs to look at the prevailing 'blame' and 'fear of litigation' culture that may be overriding the components referenced.

While we are supportive of an overarching framework which clearly sets out roles and expectations on staff alongside statutory duty of candour, success will only be achieved through leadership and sustained cultural change.

Supporting openness in everyday care

These questions focus on how organisations can make honesty and openness a natural part of daily care (further information is provided in Section 2, Section 3.3.1 and Section 7).

Q3 To support staff in being open it is proposed that organisations:

- Provide regular training for staff to promote openness.
- Share real-life examples of openness and what was learned.
- Recognise and celebrate examples of good practice in being open.

- Provide supervision that is supportive of openness.

Do you agree with these will help staff be open and honest every day?

YES NO

Comments: This may help improve openness and honesty but until any identified barriers as outlined in the previous section's comments are addressed, it may have very limited effect.

Embedding reporting responsibilities into routine business, such as team meetings and quality reviews may also help promote a culture of continuous improvement.

We believe that an individual statutory duty of candour and robust whistle blowing policies may also strengthen the support systems available to employees who report issues.

Patients and families can also play a key role in improving safety and encouraging learning as they often observe care processes closely and may spot errors or lapses that may go unnoticed by staff. By incorporating their views and perspectives as a matter of routine practice it could help build trust and foster openness.

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Openness with a focus on learning

These questions focus on how organisations learn from experience to improve care and avoid future harm (further information is provided in Sections 2 and 3).

Q4 To improve learning it is proposed that organisations should:

- Encourage staff to talk openly about mistakes without fear of unfair retribution.
- Understand the circumstances that may contribute to failures and mistakes.
- Share lessons across teams to improve safety and care.
- Make improvements visible to the public, so people know what has changed.

Do you agree that these will improve learning from experience? YES NO

Comments: Please refer to previous comments' sections. Such measures will only work if existing barriers to learning and improvement are addressed.

It is also vital to ensure that learning from SAI or other such reviews include and are shared with all those involved. Final reports with findings and recommendations must be shared with anyone who contributed to the review with outcomes shared more broadly to inform wider learning and reinforce the value of reporting and review.

Openness when things go wrong

These questions focus on when things go wrong, and how organisations and their staff handle these situations with openness, compassion, and clear communication (further information is provided in Section 3).

Q5 When things go wrong, it is proposed that organisations immediately:

- Inform patients and families as soon as possible after an incident.
- Offer apologies and explanations early.

- Provide emotional or therapeutic support to all those affected (patients; carers; staff).
-

Do you agree with the proposals for when things go wrong? YES NO

Q6 For all involved in serious incidents, it is proposed that they have:

- Timely access to information about the incident.
- Regular updates on progress and outcomes of any investigations.
- Counselling or emotional support as and when needed for all involved.
- Debriefs to discuss what happened and how to improve.

Do you think all involved in serious incidents should receive support?

YES NO

Comments:

Any future practice must be fully immune to existing barriers to implementation and the concern is that similar measures may already be in place under current guidance / operational policy but are not being adequately implemented due to those barriers.

This section sets out the parameters regarding who should be informed and supported when things go wrong. It refers to patients, families, carers and staff. It should, however, also include victims of crime and their families in order to reflect the reality of cases where a patient has caused harm to others that do not fall within the above categories. These victims and their families will also need support and need to be kept informed of processes and procedures following an incident.

The Cawdrey case is a high-profile example of this but there are other examples that can be drawn upon also. Such families have outlined their experience and how they felt completely left out of the process, with patient confidentiality and GDPR being cited as a rationale for not sharing information.

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Duty of Candour to support Openness

These questions relate to the proposals for the introduction of a statutory organisational and individual Duty of Candour.

Q7 Do you think that the introduction of a statutory organisational Duty of Candour would support organisations in their development of a more open culture?

YES NO

Q8 Do you think that the introduction of a statutory individual Duty of Candour would support individuals to be more open?

YES NO

Q9 Do you think that including a "Duty of Candour" clause in staff contracts will improve openness?

YES NO

Comments:

There is a need for a statutory duty of candour at both an organisational and individual level to ensure a more universally open culture. This will be of particular benefit in cases where things go wrong.

Statutory duty of candour on organisations and individuals should complement each other and work hand in hand. For individuals, a statutory duty of candour that is built into contracts will give individuals the 'backing' as to why they may have to flag an issue or concern about a practice or a colleagues behaviour to management.

Learning from the Muckamore Abbey Inquiry identified a failure of leadership and "lack of interest and curiosity" at trust and board level as a reason the abuse went undetected. Staff that witnessed abuse failed to stop it or report it. Mechanisms must be in place that will empower such staff and ensure any concerns they have can be raised without fear of intimidation or reprisal and in the knowledge that it will be addressed. An individual duty of candour that is built into contracts may be that mechanism.

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In talking about existing legislation and guidance, section 2.2.1 of the consultation document refers to Staff Contracts and terms of employment. The fact that this is already in place reinforces the need for additional measures and powers regarding duty of candour so that barriers to openness, honesty and learning are significantly lowered or removed entirely.

Leadership and oversight to promote Openness

These questions consider the role of leaders in promoting and monitoring openness (further information is provided in Section 4).

Q10 Should Boards of organisations and Chief Executives, through their Board Patient Safety and Quality Committee, be held responsible for creating an open culture?

YES NO

Q11 Proposals for monitoring openness in organisations

- Organisations should report and publish regularly on their progress in being open.
- Organisations should be held accountable for supporting openness by the Department of Health and regulators.
- Independent audits should assess whether organisations are meeting openness standards.

Do you agree with the proposals to monitor openness? YES NO

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Q12 Would the introduction of an Independent Patient Safety Commissioner improve openness and patient safety? (Further information is provided in Section 6.2).

YES NO

Comments:

An independent commission with key statutory powers and that can influence policy regarding patient safety would be a welcome development for Northern Ireland and bring us into line with other jurisdictions on these islands.

The establishment of any such office will need to consider how its remit aligns with NIPSO and other Ombudsmans' remit. We would expect that data sharing arrangements will be put in place to ensure key performance and outcome data in relation to complaints and other issues are shared in a timely manner.

Training and education to support openness

These questions focus on the training and support that is needed to help staff understand how to be open and honest in different situations (further information is provided in Sections 7 and 8).

Q13 Organisations should support and train staff in being open in different situations so they can:

- Be open and honest in everyday care.
- Learn from mistakes and failures to share lessons.
- Support patients and families when things go wrong.

Do you think all staff should be trained for these purposes? YES NO

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Q14 Organisations should provide support and train staff at different times using a range of training methods

- Training for openness at induction and as refresher training for all staff.
- Provision of a range of different opportunities for learning such as online or in person.
- Provision of support through mentorship, coaching and supervision.
- Learning provided in way appropriate to the staff role and the most effective training method.

Do you think all staff should be trained for in these ways? YES NO

Comments:

This training should also be built into the curriculum for the professional medical training/education institutes – eg Medicine, Nursing, Midwifery etc

Public Consultation on the Duty of Candour and Being Open Framework

Thank you for taking the time to respond to the consultation questions and in sharing your views. Your feedback is vital for shaping these proposals in improving honesty and openness in health and social care in Northern Ireland.

Any further comments on these proposals to improve openness?

The Framework does not take due account of victims that are not patients or family members of patients and how they will be supported and kept informed at every stage when things go wrong.

The Northern Ireland Victim Charter defines a victim of crime as a person who has suffered harm (including physical, mental or emotional harm) or economic loss which was directly caused by the crime. The definition includes a family member of the victim, where the victim dies; a family member of the victim, where the victim could not reasonably be expected to act for themselves, due to their physical or mental state; a representative where the victim dies or could not reasonably be expected to act for

themselves, due to their physical or mental state; and a parent of the victim where the victim is a child or a young person.

This office has had engagement with victims who suffered at the hands of patients as a result of failures within the system. It is essential that their voice is heard and their views reflected in any new model or approach to openness, honesty and learning.

The word ‘victim’ is not used at all in the consultation document.

The Health Trusts will inevitably be engaging with victims of crime in day to day operations and it is important that this broad definition is referenced and reflected in both this and other supporting documents.