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Being Open / Duty of Candour Branch
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BMA NI Response: Being Open Framework

Dear Sir/Madam

The British Medical Association (BMA) is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

BMA NI welcomes the opportunity to respond to this important consultation on the Draft Regional Being Open Framework for the HSC. We will provide some overarching comments and then specific comments on the Framework. We would recommend that our submission to the '*Duty of Candour Workstream'* in March 2019, our conference report '*Better Culture, Better Care: Creating Trust, Learning and Accountability within Health and Social Care,*[1]in December 2019 and our response to the *'Duty of Candour and Being Open*[2]*'* in August 2021 are also taken into account alongside this response.

BMA Northern Ireland's mission is that '*we look after doctors, so they can look after you,'* and patient safety defines the work of doctors as they strive to do no harm when treating patients. Modern medicine is complex and can transform the lives of patients,

[1] https://www.bma.org.uk/media/2560/bma-better-culture-better-care-conference-report-june-2020.pdf
[2] Microsoft Word - FINAL - Duty of Candour response - 2 August 21

but this is not without risk. We do all we can to minimise these risks, but it is not possible to eliminate them fully.

It is important to acknowledge that an overwhelming majority of health professionals aim to provide the best care for our patients. We completely understand that the patient or their loved ones who have experienced trauma or injury as a result of a mistake, simply want answers. They want someone to listen to their concerns and explain clearly what has happened and to ensure that where possible, no other family has to experience what they are going through. A critical test then for the trust that exists between doctors and patients (or their families) is how we deal with mistakes when they happen.

Patient Safety

We do know that most harm in healthcare results from problems within the systems and processes that determine how care is delivered, and there is a need to identify the contributory factors that have led to harm or the potential for harm to patients.

We also know that culture and the environment that we work in has an impact that affects patient safety and the quality of care. This Being Open Framework has the potential to embed the cultural change that is much needed in our health services. To have sensitive, clear and candid conversations with patients, these need to be carried out in an environment where doctors and healthcare professionals are not fearful of being penalised or punished and lessons are learnt to continuously improve care.

In order to influence the debate on patient safety in Northern Ireland, BMA NI held a major UK wide conference in Belfast in December 2019, '*Better Culture, Better Care: Creating Trust, Learning and Accountability within Health and Social Care*[3]*'.* The aim of the conference was to position key patient safety debates within the themes of creating a better culture, to hear from experts on what a caring and trusting environment would look like for patients and doctors, and what needs to happen for this to become the norm. The Being Open Framework is core in achieving these goals.

Being Open and an Organisational Duty of Candour

BMA believe that the Being Open Framework is the right approach to creating the conditions where openness and honesty can flourish and an effective mechanism to end the blame and sanction culture that currently exists.

We believe that combining the Being Open framework and the proposed organisational duty of candour has the potential to challenge the blame culture that exists and recognise that apparently simple human errors almost always have multiple causes, many beyond the control of individuals within the health service. We remain of the view that an individual duty of candour with criminal sanctions will not create the

[3] https://www.bma.org.uk/media/2560/bma-better-culture-better-care-conference-report-june-2020.pdf

cultural conditions for openness and transparency and evidence from patient safety experts all point to the need to shift the focus to system errors. As Baroness Cumberlege[4] pointed out in her report in 2018,

"We believe that barriers to being open and honest must be minimised. We share concerns with others that litigation, which is blame-based and focusses on the actions of individual doctors, inhibits disclosure. ***It has been known for decades that the majority of mistakes are system errors, yet litigation deals with the culpability of individuals.*** *Over twenty years ago in "To Err is Human", the Institute of Medicine wrote, 'The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system.* ***This does not mean that individuals can be careless. People must still be vigilant and held responsible for their actions. But when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error.'***

We endorse this approach. ***We believe that a cultural shift away from blame is needed to create a healthcare system where people are open and honest.*** *We outline how we feel a no-blame, systems-based approach to delivering redress as a substitute for litigation could drive this shift in paragraphs 2.37 – 2.39 (see also Appendix 3). We believe this shift is essential to deliver a safer NHS where healthcare professionals have no reason to fear being candid and telling the truth to their patients. Whilst we support the new emphasis on supporting whistle-blowing we are not convinced that this in itself will solve this problem".*

In our response to the '*Duty of Candour and Being Open*[5]' in August 2021 we have called for a number of actions that could have been implemented to begin the process of embedding a just culture within the HSCNI, such as:

- freedom to speak up guardians
- extending the work of the HSSIB to Northern Ireland
- fit and proper person's test
- regulation of medical managers.

We also note that the establishment of the patient safety institute as recommend by Sir Liam Donaldson in 2015 has not been progressed. Indeed, many of the recommendations from '*The Right Time, The Right Place*' in 2015 have not progressed. Section 6 of the document lists other options that may be explored. We have been engaging with the department on patient safety issues for over a decade and it is disappointing that initiatives such as Freedom to Speak up Guardians are still in the 'exploratory stage.'

[4] https://www.immdsreview.org.uk/Report.html, page 31
[5] Microsoft Word - FINAL - Duty of Candour response - 2 August 21

It is of deep concern to BMA NI that these initiatives which would contribute to patient safety and help create the environment for the much-needed cultural change are not in place and therefore not integral to this framework. This piecemeal approach is not good for patients, families nor staff.

Specific comments on the Being Open Framework

We broadly support the general concepts and levels of openness and candour as outlined in the document. One of the concerns we have is the lack of understanding of clinical practice and the relationships healthcare professionals have with patients and colleagues. Clinical practice is rarely a simple interaction with a singular issue to deal with. Medicine is rarely that simple – it is complex, difficult, risky and patients are not a simple homogenous group often presenting with many co-morbidities at any one time.

Patient Safety Commissioner: Question 12 refers to establishing an independent patient safety commissioner and BMA NI are supportive of this. Consideration needs to be given the role and function of this office to avoid duplication of existing statutory organisations and to ensure that the focus is on the structural and systems that cause harm.

Safe staffing: There must be a clear link between service quality and the provision of appropriate staff levels. BMA NI was working with the department to ensure that the forthcoming safe staffing legislation includes medical staff. However, this seems to have stalled, and no further work appears to be taken forwards. This will therefore impact on the effectiveness on the Being Open Framework as the opportunity to deliver a strong framework and joined up approach will be missed. Be in no doubt, high quality and safe care are compromised by staff shortages.

Learning: We welcome the focus on learning however our members continually report that the current system is ineffective and a failure to follow though, means that learning is not captured nor embedded. Simply sending out volumes of emails and alerts does not change practice and therefore the learning opportunity is lost.

When things go wrong: In relation to when things go wrong, the lack of a framework or process makes it difficult to provide constructive comments. We would recommend that consideration is given to the Open Disclosure process developed in Ireland as this is a clear and robust process to facilitate openness and how this links with any potential formal investigations that may be needed.

Enablers for Openness: This section is welcome, but recognition needs to be given to the current working conditions and environment. Our members report immense pressures throughout the health service putting them at risk of burn-out and stress. The provision of time and space for these initiatives will be vey welcome, but the reality is

that members are not convinced that the current environment will allow for this to happen.

General Practice: Consideration also needs to be given to how this will read over to general practice as we would have concerns with the potentially burdensome impact on this sector. General practice is experiencing long-term challenges in the form of excessive workload, depleting workforce and inadequate funding and therefore we should be wary of introducing policies, procedures and regulations that would increase the pressure on already pressurised and fragile service.

Formal Structures 3.3.1 (1): We note that there is a recommendation that employing organisations should incorporate a 'duty of candour' into their employment contracts. We would refer you to section 6 of our response in 2021 as this contains a list of the current professional duties and criminal and civil sanctions that doctors are subject to. Section 7 also details the employment contracts of our members and the links to Good Medical Practice which includes a duty of candour. We are therefore not convinced of the need to add this to employment contracts.

3.3.3 When Things Go Wrong: We look forward to seeing how new Regional Framework for Learning and Improvement from Patient Safety Incidents[6] will be integrated into this framework, once finalised. We would ask that general practice is involved in this programme of work.

Whilst this section is welcome it is important to note that it would be inappropriate to require a person to disclose any information which could prejudice any criminal investigation or prosecution or contravene any restriction on disclosure that would be prohibited.

Access to Information/Confidentiality: There are some inconsistencies in the document around the levels of information available for patients, family and service users and staff. It is important that this is clarified, and the necessary safeguards put in place.

Apology: Providing an apology when something goes wrong is the right thing to do and research from the NHS Resolution's publication, '*Saying Sorry*[7]*,* outlined how a meaningful apology when things go wrong is vital for everyone involved in an incident, including the patient, their family, carers, and the staff that care for them. At our conference, Better Culture, Better Care,[8] we outlined that a duty of candour with a meaningful apology when things go wrong is vital for everyone involved in an incident, including the patient, their family, carers, and the staff that care for them. To have sensitive, clear and candid conversations with patients, these need to be carried out in

[6] Framework for Learning and Improvement from Patient Safety Incidents Consultation | Department of Health
[7] https://resolution.nhs.uk/wp-content/uploads/2018/09/NHS-Resolution-Saying-Sorry.pdf
[8] https://www.bma.org.uk/media/2560/bma-better-culture-better-care-conference-report-june-2020.pdf

an environment where doctors and healthcare professionals are not fearful of being penalised or punished and lessons are learnt to continuously improve care.

The document is clear that an apology should not constitute an acceptance of responsibility which is to be welcome. However, members have told us that they have been forbidden by Trust solicitors and senior managers not to discuss or engage in conversations about cases they have been involved in where harm had happened. BMA NI welcomes this inclusion, but we would need further clarification at the drafting stage that this provided the protection for staff to disclose when something has gone wrong, including the provision of 'safe spaces.'

Support For Staff: We welcome this proposal to provide adequate support and protection for staff as this is an essential component in this regard. BMA NI would suggest that occupational health support is included in this section to ensure that staff can access the support that they need, including psychological support.

We note that the document refers to the need for psychological safety and this is to be welcomed, but the threat of the introduction of an individual duty of candour with criminal sanctions will make this harder to achieve.

Section 4 refers leadership and oversight mechanisms to promote openness and this it to be welcome. We are concerned that the capacity, data and expertise are not available within the system as currently organised.

HSC Leadership: We welcome the publication of the HSC Handbook for Board Members[9] as a useful resource, however, we question whether this goes far enough, given the centrality and importance of leadership. There are no mechanisms for monitoring whether board members or non-executive directors are abiding by this resource and no indication of monitoring its effectiveness. A more appropriate mechanism would be the development of the Fit and Proper Persons Requirement.

Other Components For Consideration: As noted above, section 6 lists a series of other options to be explored, and we are disappointed that these have not been developed as core components of this Framework. Unfortunately, another missed opportunity to promote a culture of openness and honesty.

Guidance: Section 7 refers to various guidance and training for staff and again welcome and it is important that time, resource and capacity is enabled within the system. How this happens is of concern to our members who are working in unacceptable conditions.

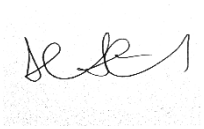
Organisational Duty of Candour: BMA NI is fully supportive of the introduction of an organisational duty of candour as this should complement the Being Open Framework. If implemented appropriately, we feel the organisational duty could play an important

[9] https://www.health-ni.gov.uk/publications/hsc-board-member-handbook

role in helping to create an HSC with an operational culture that is not rooted in blame but supports and encourages learning and improvement. However, we also believe that simply adopting the model in England may not be the best approach for Northern Ireland without some adjustments to take account of the different landscape here.

We do hope that our comments will be taken on board and would welcome continual engagement on this as this develops.

Yours sincerely



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