Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Recommendations of the O'Hara Report on Hyponatraemia-related Deaths: Department of Health

5 March 2020

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Ms Sinéad Bradley
Ms Paula Bradshaw
Mr Gerry Carroll
Mr Alan Chambers
Ms Jemma Dolan
Mr Alex Easton
Ms Órlaithí Flynn

Witnesses:

Mr David Best	Department of Health
Mr Conrad Kirkwood	Department of Health
Ms Donna Ruddy	Department of Health

The Chairperson (Mr Gildernew): I welcome Mr Conrad Kirkwood, chairperson of the serious adverse incident (SAI) work stream; Ms Donna Ruddy, chairperson of the Regulation and Quality Improvement Authority (RQIA) remit subgroup; and Mr David Best, chairperson of the death certification work stream. I invite you to brief the Committee.

Mr Conrad Kirkwood (Department of Health): Chair, thank you for the opportunity to brief the Committee on the implementation of the hyponatraemia report recommendations. You will understand that implementing the recommendations goes somewhat beyond children and paediatric services; it will have an impact across the full range of services and ages. Where possible, in thinking about implementation, we have tried to expand the scope to think in those terms. You will also understand that the implementation needs to take account of steps that have to be in place to make sure that the changes become part of normal business, not just stuff that we do when someone is looking. Everyone on the programme feels a sense of responsibility to make sure that it will sustain into the future.

I listened with interest, Chair, to your remarks during one of the sessions a week or so ago, where you highlighted the importance of co-production. Co-production involvement has been an important part of the work; over 200 members are involved in the programme. It is a varied group of people that includes service users, carers, doctors, governance leads, voluntary sector staff and even funeral directors. A great deal of time and effort has been put in to orientation, induction and research to make sure that all those members, from wherever they come, have a common understanding of the issues

in the background to support them in their work. That takes time, but it delivers in terms of their understanding of and contribution to the work.

How we implement the recommendations is important, as well as the recommendations themselves. We hope that we can try to set a positive example in how we engage and also learn lessons from what we are doing to speed up future co-production without constraining the necessary debate on what we are doing.

We have been keen to put regular updates online. You may have seen them. The last one was in December. The next one is due in June. A feature of those is interviews with people who are involved in the various parts of the programme, whether they are service users, carers or other members of the programme. That is useful; they are unedited, and we like to hear what their views are.

All of the work is guided by an involvement strategy, which outlines our co-production. Each individual work stream or subgroup has an involvement plan as to how they reach out with the work that they are doing. Justice O'Hara put candour first in his report. We aim to provide proposals to the Minister later this month. Subject to his approval and, perhaps, Executive approval, we will go out to consultation on those proposals. There will be plenty of opportunities to continue to engage on the duty of candour and for people to tell us what they think about the proposals.

It may require legislation, which may span more than one Department. If there were a criminal sanction in relation to candour, it would require other Departments to be involved. Members need to be aware that it is likely to take time; it seems unlikely that the implementation of it will fall within this mandate. However, it is not something on which we need to stand still and wait; there is a lot that we can do. With that in mind, being-open guidance, through the being-open subgroup, will issue in the summer to promote a change in culture and to try to promote openness in general in everything that is done.

The other aspect that I want to talk about is the independent medical examiner. To consider that role, a prototype has been carried out. Essentially, it confirmed that we can use current electronic patient record systems to access completed death certificates and allow an independent medical examiner to review cases. We have done that. A second prototype is under way at the moment to establish the practicalities of contacting the doctor who signed the death certificate, so that we can discuss the case with them and review it. That will give us a good understanding of the potential impact that such a review might have for families. You would not want to have any undue delay in the burial or committal process because that would be quite distressing.

In doing the work with the independent medical examiner, we have studied models from elsewhere that look at a percentage of deaths, all deaths or deaths in only the hospital sector. Ultimately, when we bring forward those proposals, it is likely that legislation will be required. That legislation could span the four Departments that are involved in the death certification and burial and committal process. The prototypes will give us a clear steer on where we are going.

You may have heard from constituents that there are issues around serious adverse incidents and that they cause concern. The purpose of a serious adverse incident is very much to establish and share learning. Bad communication can put loved ones and staff under a great deal of distress in what is an already very difficult situation. With that in mind, we will issue a guide to what to expect if you are involved in a serious adverse incident review. We use the word "review" rather than "investigation"; that choice was based on service-user input in the group. That, essentially, is a statement of patient rights. It is O'Hara's recommendation 37. It will set out the rights that you would expect. It will be incorporated into the SAI process to support not just families but the staff who help families through the process.

We felt that it was important to build an assurance process into our work. Each work stream has produced an assurance framework that clearly maps out the definitions and what it is that they are doing. Some words mean different things to different trusts and different parts of the service. It is also about how the recommendation will be implemented regionally and consistently, which is important.

Finally, it is about how it can be measured to prove that it has been implemented. We try to put it simply: no recommendation will be considered to be fully implemented until its implementation has been tested and proved over a sustained period. At this point, more than 70 actions have been through all three stages of the assurance process. A further 15 will go through later this month. We aim to pass approximately 60 of those recommendation actions for the health service, for implementation between May and December.

I have mentioned a couple of products already that we are working on, but other products will be coming out soon, including new guidance for the directors of arm's-length bodies. That will be launched in a conference in May. We hope that that will support directors of arm's-length bodies in the quality and safety aspect of the work that they do, so that they can scrutinise and take assurance from trusts. There will be revised operating procedures for pathology services. That somewhat builds on Justice O'Hara's first report around pathology services, published some time ago, that deals with consent to post-mortems and matters around that. There will be the publication of principles of candour and new guidance for staff involved in the preparation of inquests and litigation.

There are a couple more products. The online user feedback system will be launched in April 2020 and that will capture stories, pretty much in real time, from people who have experiences of the health and social care sector. That will allow us to get feedback. There will be some revisions to the Department's assurance framework guidance for health and social care bodies, and that will be strengthened. Lastly, the guidelines for clinical and social care governance will be reviewed, reinforced and reissued.

You will appreciate that there are nine work streams and seven subgroups and there is a big variation in the work, but that is a brief overview of where we are at this point. I am happy to take any questions.

The Chairperson (Mr Gildernew): Before we go into questions, I know that I speak on behalf of the Committee in acknowledging the pain that this issue has caused families. In common with a number of other issues on which inquiries are running, those families are seeking accountability, but I have been hugely impressed with their commitment to ensuring that there is genuine change in all the systems that the inquiries cover. I want to acknowledge the families at the outset.

In relation to the RQIA remit subgroup, there is reference to a review of the whole regulatory system. Can you elaborate on plans and timelines for that?

Ms Donna Ruddy (Department of Health): Yes. I am the policy lead for that review in the Department. Initially, it started off as a review of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, which underpins the rules and remit of the RQIA, and it was set up to address some gaps that had been identified. However, having engaged with stakeholders — this started in 2016-17 — we found that there was more than just the gaps, and we decided that we needed a fundamental review of regulation to bring it back to first principles. We looked at why we regulate and who would be within the scope of regulation, because the current services that are regulated are named in the 2003 Order. It excludes our primary care services, our community trust services and our acute hospitals, and, when we went out and spoke to people, we found that people were surprised at that. Therefore, we are looking at who we will regulate and how we will regulate, and it will be an appropriate regulation, depending on the risk.

I have a draft policy document. The review is to be done in two phases. The first phase was what I have just talked about — why we regulate, scope and how — and I have a draft policy document to bring to the Minister for approval to go out to public consultation. If I get that approval, we go out to consultation and we agree the principles of regulation, we will move on to phase 2, which would be to look at the specifics of each service and determine the risk.

The Chairperson (Mr Gildernew): When do you expect to come forward with phase 1?

Ms Ruddy: I hope to go out to consultation on this by the summer. There has been a lot of engagement. It has changed from what was initially thought, which was just a review of the 2003 Order. It is bigger than that. We are taking it back. There is a blank-sheet approach to this, and I hope to go out to public consultation in June. Again, it is subject to the Minister. I have not put a paper to him yet on that.

The Chairperson (Mr Gildernew): OK. And phase 2?

Ms Ruddy: Phase 1 is quite big because we are bringing in all these services and widening the scope, and we need to consult widely on that, but I am proposing to go out for a longer-than-normal consultation period. If we do begin in June, it will be the end of the year before we have finished the consultation, analysed the results and then formed our policy on that. That would then enable us to move in to phase 2, because I cannot move to phase 2 until we have completed and got complete agreement on phase 1.

On phase 2, as I say, we will go into the specifics of the risks that are identified. We need to look at what other regulation is in place, what other assessment of risk is there and then determine what RQIA would add to the assurance that is required. I mentioned primary care. Primary care has its contract and the contract is managed by the board, but we need to look at whether anything else is needed in terms of regulation from the RQIA. I do not know the answer to that yet because we have not consulted on that. Once we have gone through that, the end of phase 2 would be changes to the legislation, which could be a complete repeal of the 2003 Order and a new Act. I do not know because it is so new and we have not consulted on that stage yet. I suggest that it will be a few years before we have the legislation in place.

The Chairperson (Mr Gildernew): I understand that legislation is required for some recommendations. That makes it more difficult to estimate time frames, but what is the target date for full implementation of the non-legislative recommendations?

Mr Kirkwood: What is the target across the programme?

The Chairperson (Mr Gildernew): Yes.

Mr Kirkwood: By September, we expect to have implemented 60 of the recommended actions. You will be aware of the legislative timetable for the actions that require legislation. It is difficult to be precise about the recommendations that are in between, but, by way of example, we have resolved some of the recommendations in the paediatric work stream with the new system Encompass, which is coming into place. It will begin to roll out from 2021. There will not be a Big Bang moment in every hospital. Encompass will be rolled out on a phased basis, hospital by hospital. Five of the recommendations from the paediatric group will be part of that, so you could reasonably infer that the five recommendations will not be fully implemented until the last trust goes live. It is difficult to be precise, as everything will be done on a recommendation-by-recommendation basis. We have 60 actions to be implemented now, with 15 more actions to come through the assurance work stream. That will be 75 out of the 120 actions. We divided 96 recommendations into 120 actions so that we can work through them in subgroups. We expect something of that number to be implemented by late in the year.

The Chairperson (Mr Gildernew): Give me an understanding of how you manage the trusts' response. Do you set them targets? How do you hold them accountable to come back to you with answers in a timely fashion?

Mr Kirkwood: Which answers?

The Chairperson (Mr Gildernew): Answers about their work on the recommendations. You said that there is a bit of uncertainty because you do not know what the trusts will do.

Mr Kirkwood: No. The trusts are involved in the groups throughout. There is trust involvement in most of the groups throughout the programme. We are taking a co-production approach, so the trusts will have fed into the solutions that we develop. If we get to the point of agreeing a solution through the co-production process, there will be several parts to that. First, there are trust oversight committees. Each trust has one. They establish themselves based on their own preference, but, largely, they consist of members of the programme from the trusts who are involved in different work streams. They look at the recommendations as a whole as we put them to them. For each set of recommendations, we will have a directive from the Department that will be based on what has been agreed by the work stream. We will share it first with the trust oversight committees in order to get a sense of what a realistic timescale is for implementation so that we do not set them something entirely unrealistic. Doing that will also allow them to give us a sense check. We expect the trust oversight committees, with which we meet every two months, to identify any other areas or concerns. There will be some areas in which there is already risk in the recommendations. We will be working with the trusts, using various baselines, to ensure that any risks are managed.

Ms Dolan: Thanks very much for your presentation. Paragraph 18 of your briefing paper states that prototype exercises are being considered for an independent medical examiner system. What different prototype exercises are currently being undertaken? Can you expand on what percentage of cases you think will be examined?

Mr David Best (Department of Health): Yes. The concept of the independent medical examiner is based on Dame Janet Smith's recommendation for an independent medical examiner following the Shipman inquiry. One of the big challenges that the independent medical examiner will face is securing quick access to the death certificate in order to enable the review to be done quickly so that there are no undue delays for the family and no additional stress for them at what is a particularly difficult time.

The prototype exercises that we have undertaken involve an independent person — a senior doctor — looking at the death certificate, which, in hospitals, is currently printed out electronically. The details of the death are recorded on the regional mortality system. At present, the independent medical examiner will have access to that and will be able to view deaths as they go live, so to speak. As soon as a death certificate is completed, it appears on a list. We are currently looking at that, really to try to determine the implications of getting the doctor involved. The purpose of the review is to ensure that the details of the stated cause of death are correct; to ensure that cases that should go to the coroner are appropriately referred to the coroner; and to ensure that clinical governance issues or care issues, if there are any, can be identified and rectified at an early stage. The prototype exercise at the minute is about looking at some of the deaths as they go live and having a conversation with the doctor, and that discussion with the doctor is currently taking place. We have found thus far that trying to contact a doctor might be one of the most difficult things for people who are certifying a death at night, for example. The doctor may go off at 7.00 am and not be back for two days, and that is an issue.

Thinking ahead, we are envisaging running a third prototype exercise from September until November this year. In the first instance, once a death has occurred, we will ask the certifying doctor to make contact with the independent reviewer. We will prototype the process to see whether that reduces the gaps between when the death has occurred and the certificate is reviewed. The family are the most important thing in this, and we want to ensure that they do not suffer undue distress at that time.

Ms Bradshaw: Thank you for your presentation. How are you going to amend SAI reviews? Like all MLAs around the table, I have had constituents contact me who are very concerned about how findings are prepared and presented to them. People who are involved in completing reports may work in the voluntary sector but are being funded by the Department of Health, and constituents are concerned that they may not want to criticise the Department of Health in their reports. How are you going to make investigations a lot more robust so that families will be satisfied that a good body of work has been done for the review?

Mr Kirkwood: I met the Cawdery family, and they have given me permission to speak in the public domain about the double homicide of their parents. It was a very productive meeting, in which they described the difficulties that they had encountered in the reviews of SAIs in their case. Having spoken to them, we carried out a mapping exercise on the group in the work stream to see whether some of the issues that they identified were issues that we had either thought of before or that were being thought of elsewhere.

I will talk you through the rights that you would expect to have if you were involved in an SAI in part. I will then talk a bit about independence, which will give you a flavour of where we are at. Your rights are that you should be listened to, respected and responded to in a timely fashion. We perhaps struggled with openness, honesty and empathy initially. I recall that Charles Little, the couple's son-in-law, speaking for the family, said that people should have intellectual curiosity about reviews or investigations going forward. He felt that the chair of a review panel should have what we refer to in our group as an engagement plan, which establishes the contract between the review panel and the family on how often the two will be in contact. Service users on our work stream described it as a sword of Damocles hanging over you for a time, where you are waiting for a phone call. You do not know whether anything is going to happen, and you are worrying. The contract that was established with the Cawdery family was that the chair would ring them every second week on a Friday, whether or not there had been any progress, to give them comfort.

We would describe that in our work as an engagement plan. A link person is useful to have in the process. We have been shown some videos from a family in the Southern Trust that were used at all of our engagement events. Those demonstrate the important nature of a link person. A link person can signpost people through the trust and help them, because the process is complicated. It is very important to have a single point of contact.

Families should have access to relevant information. They should not feel, to use O'Hara's language, that you have to drag information out of people. They have the right to independent advice and support. The Cawdery family ultimately did access some independent advice and support from the

Patient and Client Council (PCC) that they found helpful. It is those kinds of things that were useful to the family.

You mentioned independence. Some families involved in cases will say that if the trust is paying for an SAI review, it is not truly independent. The Public Health Agency (PHA) and the Health and Social Care Board are working closely with other policy officials in the Department to look at other ways in which independence might be delivered. It might be that there will be a central panel of people, who are at a remove from the trusts, and that you will go through the board or the PHA to get to it. At the minute, that is really only being considered for level 3 serious adverse incident cases, which amount to fewer than a dozen cases a year. That thinking is not excluding level 2, which is a larger group of cases. The idea is that the independent panel will have a greater level of independence because the trust does not get to pick its members. From my recollection, that idea did not necessarily come out of the Cawdery family case, but people were concerned about whether the review panel had received adequate training for everything that they were trying to do. That includes training for the chair, training in how to deliver difficult messages or how to speak to people in difficult circumstances, or training in investigative or review methods and root-cause analysis.

Moreover, it was felt that, if you are introducing truly independent people, who might be from beyond these shores, there needs to be someone on the panel who can navigate the system for them and explain how our SAI system works, because it is undoubtedly subtly different from others, and someone who knows how Northern Ireland's health and social care system works, because it is an integrated system. There is a lot of thinking around that, and it was very helpful to speak to families such as the Cawdery family, who shared their experience with us fully and constructively.

Ms Bradshaw: The second part of this relates to the child death overview panel. Can you give us an update on that today, please?

Mr Kirkwood: Surely. We have been in contact with the Children's Commissioner, who has a strong interest in the matter. First, we need to take account of O'Hara's recommendation 88, which referred to considering arrangements for a child death overview panel and looking at what those might be. He was specific in his language.

There was a review of the Safeguarding Board in 2016, and it is to the board that the panel eventually could be attached. Other jurisdictions in the United Kingdom have had a child death overview panel in operation for a while. There are lessons to be learned from their experience, and it is important that we do so. The Public Health Agency and the Department have further work ongoing, and there has been regular contact with the Children's Commissioner to try to move the issue forward.

Ms Bradshaw: OK. People will be very disappointed if, at the end of this process, there is another excuse for why we do not have a child death overview panel. I will watch with interest. Thank you.

Mr Kirkwood: Thank you kindly.

Mr Carroll: Thanks for your comments. I join you, Chair, in supporting and paying tribute to the families who are seeking justice and answers and who are courageously trying to prevent something like this from happening again, which is very important. I will follow up quickly on Paula's last point on the child death overview panel, because there seems to be a slowness in implementing that recommendation. From the Department's perspective, is there any reluctance to proceed with the child death overview panel?

Mr Kirkwood: The Department is engaging with the Children's Commissioner to work towards a solution. There is no reluctance to work with her.

Mr Carroll: OK. Thank you. I have one other question, Chair. Is it time to have a deputy chief medical officer to oversee children's healthcare so that, from the Department's perspective, it becomes a highest-level priority, ensuring that there is a clear channel of reporting in any cases like this again? How effective would you consider it to be to have a deputy chief medical officer specifically for children's healthcare?

Mr Kirkwood: Thank you for the question. First, I will say that a deputy chief medical officer would be responsible for giving professional medical advice and support to the Department. "Children's healthcare" is a very broad term. The inquiry report is important, and it was about children and a sad

loss. Through the inquiry report's recommendations, we are trying to establish patient safety in a greater context, which is across all age groups.

Depending on which legislation you are operating under, and there are several pieces of legislation, and which services you are accessing, it is apparent that the definition of a child or the age point at which you no longer consider someone to be a child differs. Indeed, for young people with a learning disability, there is also a transition period, during which their family may not consider them to be entirely an adult yet, even though they may be beyond 19. The Department's approach is to identify the patient safety element very clearly for everyone under a deputy chief medical officer and to make that a locus for all patient safety issues. We will recruit a deputy chief medical officer on that basis.

Mr Carroll: To clarify, do you mean for childcare or for healthcare?

Mr Kirkwood: It is about patient safety for all ages.

Ms S Bradley: Thank you for your presentation. I add my words of support to the families behind the report. It makes for hard reading when you know about the experiences that have led to it.

Some of the report's recommendations fall specifically to the Department. It is difficult to call them easy-reach recommendations, because I know how difficult it is to recruit consultants at this time, but are there assurances that you can offer us today that, on wards, people can take some comfort from?

Mr Kirkwood: Do you want me to set that question specifically in the context of paediatric units?

Ms S Bradley: Yes, please.

Mr Kirkwood: OK. The paediatric work stream very clearly and early on placed its focus on recommendations that it considered to be of the highest priority. It was into age-appropriate care for children. For example, it focused on children who might have surgery on an adult ward in a district general hospital as opposed to moving to the Royal Belfast Hospital for Sick Children and considered the cooperation and work that needs to happen between the surgeon and the paediatrician in such cases. O'Hara focused on the prescription of intravenous fluid, which requires a paediatrician in such circumstances, but it goes beyond that.

You are right to say that the recommendations in the paediatric section are more operational by nature, if that is what you are saying. The Department's paediatric strategy was published in 2016 and was recently reviewed by the RQIA. It sets out some of the direction in which we need to travel anyway.

The way in which I would describe the recommendations, and I am not sure whether this is how O'Hara meant them, is that they are a series of recommendations that intend to deliver regional consistency across all paediatric units and wards; that intend to clarify roles and responsibilities and accountability so that we are sure who is in charge, and when and where; and that intend to ensure that there are multiple opportunities. The management of the deteriorating child is very difficult for medical professionals. Oftentimes, it might be the parents who notice rapid deterioration or improvement first. O'Hara's recommendations 10 to 30 are very much about creating as many opportunities as possible for medical professionals to engage with parents and families and also opportunities for parents to find medical professionals to engage with if there is an issue. That covers actions such as having a consultant do a week in a paediatric setting so that there is always somebody in charge whom parents can go to. A very useful project in the course of our work in one of the trusts was paediatric bedside handover by nurses. That proved very important, and it captures what parents have to say about their child.

You highlighted at the start the safety element and the managing risk element. We carried out a baseline assessment soon after the establishment of the implementation programme to satisfy ourselves that risks, if there were any, were being managed whilst we were in the process of developing the recommendations further.

Ms S Bradley: I have one minor point to raise. You mentioned that you were extending the consultation process.

Ms Ruddy: I meant the timeline. Normally, we go out to consultation for eight weeks. My intention is to go out for longer, but I have to seek ministerial approval for that.

Ms S Bradley: OK. What are you thinking? Twelve weeks?

Ms Ruddy: I am thinking at least 12, because of the wide range of stakeholders that we have to engage with. Stakeholders include those services that are not currently regulated by the RQIA and that are, we think, within the scope of services that the regulations should cover. We are therefore looking to extend for that reason. I am also mindful of the fact that the consultation will run over the summer, which is another consideration.

Ms S Bradley: I appreciate that. Thank you.

Ms Ruddy: I would be happy to give the Committee a briefing on where we are to date with the review and what our intentions are.

The Chairperson (Mr Gildernew): I want to revert to the issue that Paula raised about SAIs. You mentioned a link person, Conrad. Is that link person mandated at present? Does everyone get a link person?

Mr Kirkwood: It is not mandated in policy from the Department at present. It is something that some trusts provide. The best example that we have was in the Southern Trust. Someone was a link person for a family with very difficult circumstances and signposted them around the trust.

I should say as well that having a link person works. There are probably three roles that all help. There is the bereavement officer, who will deal initially with someone who has suffered a loss, and there are bereavement officers in each of the trusts. We are looking to have a link person in each of the trusts to support families with signposting. Moreover, through the user experience and advocacy group, we are working towards the idea that there will be a positive offer of advocacy up front, rather than, "We will give you a piece of documentation about advocacy through the Patient and Client Council". Instead, someone will make a call and try to help people through the process.

I was struck by how very articulate and intelligent the Cawdery family were and by how they worked their way through the system very successfully. The challenge to us is to provide advocacy so that everyone can navigate a way through the system to the same extent.

The Chairperson (Mr Gildernew): That is a crucial point, and I would like to see that brought in as a requirement. My experience of dealing with one particular high-profile inquiry that is going on at present is that it took me six months to find out which trust had done an SAI review. It had been referred to as a summary care record (SCR), and a number of trusts were involved. I was coming at that with experience of working in the system as a social worker, yet I struggled with it. That is for noting.

Another thing to note is that I am aware of another case, in which the professional who was the subject of the SAI review was the person who reported back to the family on the outcome of that SAI. That is absolutely unacceptable and inappropriate. It challenges the whole independence of the SAI process. Those things need to be considered. Having a link person who acts as an advocate, enabler and facilitator for families would be hugely beneficial.

I ask you to speak up for the benefit of Hansard.

Mr Kirkwood: I do apologise.

The Chairperson (Mr Gildernew): It can be quite hard to hear in the Senate at times. We all struggle a little with that.

The other issue that I want to ask you about is the duty of candour. Where is that at at present? How have you gone about engaging in that work? What are the plans from this point forward?

Mr Kirkwood: That will take a little while to answer, if that is OK.

The Chairperson (Mr Gildernew): OK.

Mr Kirkwood: There have been eight research papers done so far on the duty of candour. I talked earlier about co-production and the need to ensure that everybody has a common understanding of what is, or could be, meant by "duty of candour". In the early days, we had people who were very vocally opposed to a duty of candour, even though we had not yet defined what we felt it meant in our jurisdiction. We got a number of key learnings from the eight papers. We put out public calls for evidence from the various professional bodies, regulators etc. We carried out an exercise to identify the legislation and to establish the legal position as well as the human rights position. Quite a lot of the work was largely us getting information.

We had engagement events across all the trusts and spoke at all kinds of events, including for the British Medical Association and the British Dental Association. We have engaged with trust boards and trust oversight committees. We have gone anywhere where anybody will listen to us talk about candour. There has been quite a big exercise done around involvement and engagement. We have also taken on board information that people provided online in response to the call for evidence.

We have got to the point at which it is about being open. The being-open work can be carried out in advance of a duty of candour being implemented, if we get that far. It is about changing the culture. It is about making openness more routine and promoting it. It is about trying to share learning and supporting service users to make it more possible for them to speak up if they have an issue.

We looked at legislation elsewhere. Wales essentially has a system of regulation. It has not moved to putting the duty in legislation yet but will probably do so in 2022. England implemented its duty in 2015 following the Francis report. There was no individual duty of candour attached to that. England went for a model of what it would describe as enhanced professional regulation. There are already professional regulatory codes for doctors, nurses etc that encourage them to have candour. Scotland implemented its duty of candour in 2018. It is a little different from what we might think of having, in that it does not consider near misses. The South has an open-disclosure policy and will make that mandatory by way of legislation. The sanction will apply not to the individual but to the organisation. There is therefore a big difference in how people are doing things.

There are lots of sanctions to consider before you get to a criminal one. A sanction could mean training and support initially. It could mean performance review. It might mean disciplinary action. From there, a sanction would move on to professional regulation and, ultimately, a criminal sanction. We are also interested in what the thresholds might look like. You would not expect to be sanctioned for making a mistake. You may make a mistake in the course of your work, and you need to learn from that. The idea of the duty of candour is that you should not cover up a mistake or withhold information about it. We looked at where there are other thresholds and found that how other jurisdictions describe "harm" to be inconsistent. They all have different levels of harm, whether that be serious, moderate or prolonged psychological harm, and that pretty much ties into the model of clinical and social care governance that there is in England, Scotland, Wales or wherever. We need to map our clinical and social care governance to what a new threshold might look like, and doing that is quite complex.

Moreover, other jurisdictions' legislation is subtly different. Donna has already talked about the RQIA's legislation around a duty of equality. Different organisations are required to be registered under the law, so there is a big difference. O'Hara sums it up nicely in one of the comments that he makes in the report:

> *"All that is required is that people be told honestly what has happened and a legally enforceable duty of candour ... will not threaten those whose conduct is appropriate."*

That nails the thinking.

There are five principles that we are looking at around the being-open guidance that is coming out. There should be routine candour in everything that we do. There should be candour when we have a near miss and it is something that we need to learn from. There should be candour when something goes wrong, such as when there has been a death. There should be adequate support in place to allow for candour. There should be governance arrangements in place to make sure that candour happens. There has been quite a lot of work done there.

How might our legislation look to implement O'Hara's recommendation? It will go further than anybody else's. If candour were an individual duty with a criminal sanction, it would not be limited to harm but would link very closely to culture and openness. The being-open subgroup and the duty of candour group are working closely. They do all their consultations together.

We need to avoid unintended consequence, however. We do not want to discourage people from wanting to work in the health service, so we need to be careful there. O'Hara said that he had to drag the truth out of witnesses in some cases, and he found that difficult. We also need to be mindful of the fact that there are already offences that are not part of a duty of candour but to do with withholding information. Those offences are contained in the Freedom of Information Act and the Inquiries Act. Indeed, there are requirements for inquests in the Coroners Act, so there is existing legislation out there.

The being-open element is really about listening, telling the truth and being compassionate. That is some broad-brush background information on the duty of candour. Ideas have not coalesced into a single option yet. The candour group is still working through where it will go with a duty of candour, so it would be wrong of me to pre-empt what it might decide in the next week or so. It could be that the options are a duty of candour with a criminal sanction, a duty of candour without one or a duty of candour with a criminal sanction for withholding information. There may be other options.

Ms Bradshaw: How are you interacting with and learning from the independent panel on the neurology recall? What do you know of its findings and learning around sharing information and bringing it to the relevant people?

Mr Kirkwood: We are aware in the sense that we respond to its requests to provide information. We are aware of the sort of information that it is asking for, and that gives us some insight into the panel's thinking. We look forward to the outcome of the report and where we end up going with it. We will take its findings into account as they arise.

The Chairperson (Mr Gildernew): We have heard in Committee previously about concerns around an individual duty of candour being introduced at the expense of holding the organisation to account. What is your view on that?

Mr Kirkwood: At the expense of the organisation?

The Chairperson (Mr Gildernew): Yes. It has been said that having an individual duty of candour may in some ways allow the organisation not to be as responsible.

Mr Kirkwood: It would be wrong of me to give my view on that. The work stream on candour is going to work through the options over the next week or so and then put them to the Minister. The group has not settled on one option as yet, and it has not formalised its proposals. It would therefore be wrong of me to pre-empt. I should not interfere with the group's work. That was a principle of establishing the group.

The Chairperson (Mr Gildernew): As a Committee, we are very conscious of the need to support staff, but the duty of candour does not necessarily need to be something that is solely to the detriment of staff. Candour and good culture can provide staff with the reassurance that it is OK to come forward. On the range of issues that we are dealing with, and not only those linked to the hyponatraemia inquiry, we need to see a very quick turnaround. People need to be able to get accurate information in a timely fashion and in a way that supports them rather than adding to their grief, stress and distress.

That is the end of the session. Thank you very much for coming along to provide your briefing and answer questions.