Mr Simon Hamilton, MLA  
Minister for Health, Social Services and Public Safety  
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The Right Time, The Right Place: An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland

Dear Minister

Please find enclosed BMA Northern Ireland’s response to the above consultation. We welcome the opportunity to respond to this consultation and if you need any further clarification on any of the issues raised, please do not hesitate to contact, Judith Cross, Senior Policy Adviser, on 02890269687 or jcross@bma.org.uk.

Yours sincerely

Dr John D Woods
BMA NI council chair
The Right Time, The Right Place: An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland

Introduction

BMA Northern Ireland is both a Professional Association and a Trade Union which represents the medical profession in Northern Ireland across all Branches of Practice. Our mission is “we look after doctors so they can look after you”.

BMA has 155,000 members worldwide, and 75% of doctors and medical students are members in Northern Ireland.

BMA Northern Ireland welcomes the opportunity to give evidence to the Minister in response to the Donaldson Report, ‘The Right Time, The Right Place: An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland.’ BMA Northern Ireland fully supports doctors playing a central role in creating an open and honest culture where patient safety is paramount.

Northern Ireland has a world-class medical workforce and patients rightly expect accessible, high-quality safe care delivered by highly skilled clinicians across all specialties and in all settings. However our members report that external pressures such as prioritisation of financial targets over quality of care, under-funding and the failure to recognise the importance of professional development activities have compromised their capacity to deliver high quality care to their patients.

It is not BMA Northern Ireland’s intention to respond to all 10 recommendations in the report, but we will address the issues that are pertinent and necessary to creating an environment that is clinically led and delivers quality and safe care to our patients.
Overarching comments

BMA Northern Ireland met with Sir Liam Donaldson and his team in December 2014. Our key overarching message was that our members are committed to identifying opportunities to improve quality and standards, but the environment is not necessarily conducive for this to happen for a number of reasons which we explore throughout this response. Our members have consistently called for more genuine clinical involvement and engagement in delivering safe and effective care for patients and we welcome the recognition of this in the report.

In many instances the report goes further than an examination of the quality and safety of care in Northern Ireland. We are pleased to see the report recognises that health and social care in Northern Ireland is subject to the same challenges as elsewhere in the UK and that care is likely to be no more or less safe in the UK or any comparable country globally.

However, BMA members are not complacent and as clinicians we see daily the potential for learning but we are also aware of the limitations of the current system due to a number of factors - pressures to prioritise financial targets over clinical need coupled with a workplace where warnings are ignored or advice dismissed. At worst, these conditions create a climate of fear and allow those with no clinical expertise nor direct responsibility for clinical outcomes to have the balance of power.

Clinicians must be allowed to deliver high quality care for their patients and exert a positive influence across health and care but for this to happen fundamental changes in Northern Ireland’s health and care culture must occur.

In addition, we were pleased that the report highlighted the intense, negative media and political attention given to acute and unscheduled health care. This narrow focus by the media and politicians is unhelpful, counterproductive and disproportionate.
BMA Northern Ireland believes that we must move away from a system that simply prioritises targets to one which takes a wider view of how services are performing. We must look at health and social care in its totality, and ensure that every part of the system is fully funded, appropriately staffed and producing high quality outcomes for patients and communities.

Transforming Your Care

The report rightly points to the frustrations of the lack of progress on Transforming Your Care (TYC) and our members share that frustration. BMA Northern Ireland has consistently called for TYC to be planned, managed and resourced. We remain supportive of the intentions and theory behind TYC, but we are not convinced that the appropriate resources needed to make this a success have been allocated. A key barrier in the implementation of TYC appears to have been the failure to transform the current funding processes in line with proposed service changes. We appear to have been asked to play a new game, but with the old rules.

We were somewhat surprised at recommendation 1: coming together for world-class care, but, our members understand the reason behind this. For an external expert to make a recommendation that a report’s findings be agreed in advance, regardless of what those findings are, appears to be a symptom of the lack of commitment to change in Northern Ireland perceived by Sir Liam Donaldson.

Our members, similar to the general public, are only too aware that despite review after review making similar recommendations, particularly around the delivery of acute care and the need for more resources in community care, little seems to change. The report acknowledges that political pressure often acts to resist change and indeed this can run counter to patients’ interests.

We are aware of numerous examples of service “closure by collapse” in Northern Ireland, where a service is run to the point where immediate closure is the only safe
option. This approach is not good for medical and care staff, patients or communities. Further, this type of closure can be avoided by properly engaging with clinical staff as normal management practice, putting in place a system where the views of front line staff can be heard throughout the system, not just when a crisis occurs. When changes do occur, they should be effectively planned, managed and resourced, and take into account the views of doctors working in the service, in both secondary and primary care.

We were struck by the attention paid by the media to Donaldson’s views on the number of acute hospitals in Northern Ireland. In common with previous reviews, he has recommended a reduction in the number of acute hospitals. BMA Northern Ireland’s view is that the focus should be on service provision to suit the needs of the community. The infrastructure should follow the design of an effective service, rather than the other way round. Financial pressures appear to lead some trusts to panic to “get rid” of buildings, rather than considering the ways in which services could be redesigned to better serve patients. We would advocate that doctors in both secondary and primary care settings be brought into these discussions.

**GP Federations**

Our GP members have been detailing how workloads in primary care are increasing inexorably without an equivalent increase in funding. As a result, primary care is under severe pressure. Our recent report, ‘General Practice in Northern Ireland: the case for change’\(^1\) details the crises in general practice and calls for the need to increase funding of primary care with an immediate investment of £33 million to bring Northern Ireland up to the UK average\(^2\).

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\(^1\) BMA Northern Ireland, (2015) General practice in Northern Ireland: the case for change. BMANI. Belfast

\(^2\) Ibid, page 5
Whilst GPs are under pressure they are identifying and implementing solutions to ensure that primary care remains central for their patients. BMA Northern Ireland’s GP Committee has been responsible for the creation, development and implementation of a network of Federations of GP practices across Northern Ireland. This model can help to support the aspirations of Transforming Your Care while at the same time addressing the workload and workforce issues contributing to the crises in general practice.

These not-for-profit community interest companies have the potential to: support primary care to work at the scale needed to increase the range and type of services in the community; reduce demands on emergency and outpatients departments; and free up a general practitioner’s time to deal with their patients who have complex co-morbidities and long-term conditions.

This is an example of the innovation of clinicians who have pushed ahead with new models of care that are in the best interests of their patients and of the communities they serve.

**Commissioning of services**

BMA Northern Ireland welcomed the report’s recommendation 2: strengthened commissioning. Northern Ireland requires sustainable health and social care system, and this must be delivered in the face of unprecedented financial and social challenges. Achieving this requires a re-orientation away from the emphasis on acute and episodic care towards prevention, self-care, and primary care within an integrated structure. This is the thrust of TYC, but commissioning has not kept pace, or indeed facilitated this re-orientation. Successful commissioning can only be achieved when doctors from all specialties play a central role in the design and commissioning decisions – GPs, consultants and specialty doctors. Hospital doctors in particular feel removed from the current commissioning process. In primary care, the Local Commissioning Group (LCG) model in place for the last 7 years has not resulted in genuinely local commissioning at a scale that would result in service improvement across Northern Ireland. This appears
to have been partly due to the reluctance to devolve budgets of significance from the centre to the LCGs. Commissioning in the NHS was intended to drive up quality and drive down price by creating a purchaser-provider split. Current commissioning appears overly bureaucratic and it is highly questionable whether the cost of running commissioning in Northern Ireland balances against the gains it gives patients.

BMA Northern Ireland remains committed to the principles of the NHS and is opposed to the commercialisation and the active promotion of a market approach in the NHS. The process of planning and provision must be led by the public sector and there should be no role for the private sector in commissioning public services. We do not accept that the tariff system is conducive to good patient outcomes.

Commissioning models that put doctors at the heart of the commissioning process will result in better integrated, high quality health services that are based on the needs of their patients. This means ending the inappropriate redefinition of commissioning as a procurement method and instead returning to a planning function that is clinically led and based on collaborative relationships between primary, community and secondary care and public health.

A commissioning system based on market competition and division, and that actively discourages collaboration cannot develop co-ordinated services that deliver the best care for patients. Furthermore, the administrative burden and cost of competitive tendering are significant and there is no evidence to show that this procurement route provides value for money. It is therefore essential to question whether the continuation of the ‘internal market’ in commissioning in Northern Ireland is appropriate. BMA Northern Ireland notes that the Scottish government in 2004 and the Welsh government in 2009 removed the internal market mechanisms and reintegrated the commissioners and providers of health so that services are planned and delivered together. BMA Northern Ireland asks that any review of commissioning in the light of the Donaldson report include BMA representatives from both secondary and primary care on its steering group.
Delivering Safe and Quality Care

BMA Northern Ireland welcomes recommendation 8: a beacon of excellence in patient safety, and acknowledges that the responsibility for patient safety is often confusing and complex. The report points to a ‘...complex interweaving of responsibility for patient safety...’\(^3\). We accept that day-to-day out-workings of patient safety may lie with various bodies and individuals, ultimately however, the responsibility and accountability for all aspects of patient safety lies with the Department of Health, Social Services and Public Safety.

As previously mentioned it is not our intention to comment on each recommendation in the report. The following sections highlight the issues that are relevant to our members. As such we comment on commissioning of services, the duty of candour, whistleblowing and reporting and monitoring. The next sections highlights some of our member’s views on serious adverse incidents.

- BMA Northern Ireland Member Survey of Adverse Incidents

BMA Northern Ireland undertook a brief survey of our members in November 2014 asking them about their experiences of the serious adverse incident (SAI) process\(^4\). Figure 1 below highlights that 78% are unaware of who is responsible for the management of adverse incidents in their Health and Social Care Trust.

\(^4\) BMA Northern Ireland (2014) Member Survey of adverse incidents, November 2014
Other highlights include:

- 76% are not aware of the policy or procedure for dealing with adverse incidents
- 78% indicated that they believed that there is an under-reporting of adverse incidents and when asked why this is the case, 34% cited uncertainty with the process
- Some members also reported that fear was a factor in inhibiting doctors from reporting adverse incidents.
BMA Northern Ireland notes that part of recommendation 6: making incident reports really count, refers to the introduction of a duty of candour consistent with similar action in other parts of the United Kingdom. We also note the Minister’s comment in his oral statement to the Assembly on 27th January 2015 where he confirms that a statutory duty of candour will be introduced in Northern Ireland and that officials are to begin this process.

BMA Northern Ireland supports the principle underlying the idea of a duty of candour and we believe that all NHS organisations, providers and staff must be honest and transparent in everything that they do in order to best serve and protect their patients. However, BMA Northern Ireland believes that it is important that the Department does not cherry pick bits of initiatives without first examining how relevant and suitable they are for implementation in Northern Ireland.

BMA Northern Ireland, like others was deeply saddened by the failures at Mid Staffordshire NHS Trust which resulted in tragedy for many patients and their families. An environment lacking in openness, transparency and candour meant that there was a fear of raising concerns, a learned tolerance of poor patient care and a failure to put patients first. It is therefore essential to create the right organisational environment for professional values to thrive and to achieve high standards of patient care.

When we met with Sir Liam and his team in December 2014, we highlighted that the overarching message from our members was that HSC organisations had not yet fully embraced the potential for learning from the Critical Incident Reporting process and the lack of leadership shown by some managers is of deep concern to clinicians. If clinical leadership is to make a genuine difference, doctors must not just be at the forefront of care and treatment, they must be an integral part of health and care decision making. However, the pressure of workloads in both primary and secondary
care means that doctors are not given the necessary time or training to undertake and conduct investigations. BMA Northern Ireland is urging the Minister to talk to and listen to senior clinicians and other healthcare professionals to utilise their expertise as this will be vital if we are to create an environment of openness and transparency where reporting is seen as a normal, routine and everyday part of clinical governance.

Organisational Duty of Candour

BMA Northern Ireland supports an organisational duty of candour for providers of health and social care. Organisations across the NHS should also be open and honest with patients about their care and an organisational duty of candour could potentially improve the current organisational culture, and complement the existing regulation for individual doctors. However we have significant concerns that the additional administrative burden, costs and responsibilities being introduced without additional resources and, at a time of increasing financial pressures, will be onerous on doctors and other NHS staff. This additional function, coupled with the continued under-investment in health and social care, threatens the stability of the NHS in Northern Ireland. Therefore any additional workload would need to be fully resourced, particularly around training and ongoing support for clinicians and introduced in such a way that reduces unnecessary bureaucracy to avoid diverting scarce resources from patient care.

Particular consideration needs to be given to the impact of this statutory duty of candour on individual GP practices. GPs are self-employed contractors, some of whom work in small organisations and the introduction of a statutory duty of candour could be cumbersome and unworkable for many general practices. Therefore consideration needs to be given to ensuring that the introduction of a duty of candour on general practice is reflective of their particular circumstances.
Existing Professional Duty for Doctors

Doctors already have a professional duty to be open and honest with patients about their care through *Good Medical Practice*\(^5\), the professional code governing their fitness to practice. Breaching this code can lead to a doctor’s removal from the medical register and a loss of their ability to practice medicine.

Within the medical profession, doctors are expected to be open and honest with patients when things go wrong. Doctors are strictly regulated by the General Medical Council which is an independent, accountable regulator and has a duty to ensure proper standards in the practice of medicine\(^6\). The General Medical Council’s Good Medical Practice Guidance states:

“30. If a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects.

“31. Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response including an explanation and, if appropriate, an apology. You must not allow a patient’s complaint to affect adversely the care or treatment you provide or arrange.”

Good Medical Practice clearly sets out the principles and values on which good practice is founded and these principles together describe medical professionalism in action. The guidance is initially addressed to doctors, but it is also intended to let the public

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\(^5\) Good Medical Practice, GMC www.gmc-uk.org/guidance/good_medical_practice.asp

know what they can expect from doctors. If doctors do not adhere to the principles outlined in Good Medical Practice, their registration can be called into question.

BMA Northern Ireland does not accept that an individual statutory duty of candour on individual doctors is necessary. We believe this could have the opposite effect of that intended and that it could, in practice, act as a barrier to transparency. The threat of criminal prosecution for an act committed in the course of treating a patient (whether accidentally, negligently or purposefully) could, instead, worsen the culture of fear amongst professionals that prevents people speaking out. Even where a staff member was confident that no single individual was to blame for the action that endangered or misled a patient, concern about criminal prosecution may discourage them from speaking out. The threat of criminal sanctions may also encourage more defensive practice in medicine.

- Whistleblowing and freedom to speak up

BMA Northern Ireland welcomes recommendation 5: Better Regulation, in relation to the RQIA reviewing the current policy on whistle blowing and providing advice to the Minister. Doctors are acutely aware of the importance of preventing harm to patients – this is a fundamental pillar of doctors’ professionalism and the GMC expects doctors to make the care of their patients their first concern and to take prompt action if they think that patient safety, dignity or comfort is being compromised. It is therefore vital that the organisations doctors work within are learning environments that create the conditions for them to raise concerns without fear of reprisal.

We also reported to Sir Liam and his team that our Junior Doctors in particular raised a number of issues pertinent to them at the start of their careers. They highlighted a reluctance in reporting incidents as they perceived it could potentially impact negatively on their career progression. We proposed that if addressing this was part of
the core curriculum for doctors, it may go some way to reducing this fear and also contribute to the necessary cultural shift needed to enable doctors to speak up.

It is vital that doctors and all workers feel they can speak up for patient safety without risking hostility from management, colleagues or the media. There have been high-profile cases of doctors who have been ignored, silenced or even punished by their employers after raising safety issues. In order to address an underlying culture that may discourage people from speaking up, employers should have a duty to listen to staff when they do report concerns, and to protect them if necessary. Staff should be encouraged and recognised for following their professional guidelines. More training may be necessary to help people communicate more effectively when, for example, treatment has not gone as well as expected or an error has occurred in the process of their care. More effective policies addressing bullying are also necessary.

We note that Sir Robert Francis published his independent review into creating an open and honest reporting culture in the NHS, *Freedom to Speak Up*. In our response to this report we believe that the Public Interest Disclosure (Northern Ireland) Order 1998 does not give our members adequate protection. The main issue in practice lies in showing that the detriment or dismissal is linked to the disclosure. Legally there will be grounds to take action only where it can be shown that the protected disclosure has ‘materially’ influenced the employer’s treatment of the whistle-blower. In many cases however this will not be clear. For example, if the concern is raised in the context of a dispute with a colleague, a forthcoming re-organisation or a threat of disciplinary action, this may create doubts as to whether the employer’s subsequent actions have been influenced by the disclosure. The RQIA in their review may wish to devise ways of strengthening the legislation.

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7 Francis, R (2015) *Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS.* Sir Robert Francis, QC
BMA Northern Ireland would recommend that consideration is given to placing a duty on healthcare providers ‘to listen and learn.’ We believe that this sends a positive and reassuring signal to staff that they can raise their concerns without fear of punitive action. Rather than a legally enforceable duty, this could sit alongside the duties on NHS employers as custodians of public resources and chief executives of Health and Social Care Trusts would be held accountable for its discharge.

We further recommend that NHS employees who raise concerns but are not satisfied with the response from their employers should be able to get their concerns referred to an independent body that can investigate whether there is a public interest issue and can advise – and, if necessary, criticise – the employer. In practice, this could prove to be a means of avoiding unnecessary disputes. Employers would not be permitted to use referral to such a body as an excuse for having failed to act on the concerns themselves. BMA Northern Ireland believes that these recommendations can facilitate some of the intentions behind recommendations 6: making incident reports really count; 7: a beacon of excellence; 8: system-wide data and goals; and 9: moving to the forefront of technology.

• **Reporting and Monitoring**

Linked to recommendations 7: a beacon of excellence in patient safety; 8; system wide data and goals; and 9: moving to the forefront of new technology, BMA Northern Ireland believes that good systems and data are needed to enable clinical teams to identify and rectify problems as early and quickly as possible. A system that is straightforward to use will encourage staff to report all events including ‘avoided events’ and ensure that the information is collated in such a way to allow for monitoring and emerging patterns. Therefore the development of metrics and technology to assist in this is welcome. We would stress that the introduction of new
systems and processes must not be overly bureaucratic or seen as an administrative
process and designed to ensure that this is truly an opportunity to improve quality.

We are unclear what the intention is behind the establishment of a clinical leadership
academy in recommendation 8: system-wide data and goals, and that all clinical staff
pass through it. There is an increasing emphasis placed on consultants and other senior
doctors including staff, associate specialists and speciality doctors to manage and lead
the service. We would call for all doctors to have the opportunity to have leadership
development across the service, and that this this is not only restricted to those who
are currently in leadership or management roles.

In our response to the Clinical Excellence Awards consultation we recently highlighted
that consultants are key players in HSC clinical teams and are needed to manage and
lead the service. However workloads are increasingly making this impossible and the
lack of recognition of excellent work will result in consultants concentrating primarily
and possibly solely, on core responsibilities. This would mean that they would be less
likely to take on additional unpaid work such as teaching, research, management,
leadership roles, committee and local service development. The recent years of below
inflation pay awards for consultants, combined with cuts to award schemes will take
their toll on the level of engagement by consultants in the wider work that supports the
NHS and healthcare generally.

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Conclusions

BMA Northern Ireland believes that the Donaldson report can be a catalyst for meaningful change. We accept that clinical leadership is fundamental to this and we reiterate our call for doctors to be meaningfully involved in service development and leadership. However, in the absence of political leadership, change will be piecemeal and incremental.

Furthermore, the recommendations from the report must not be considered in a vacuum and wider issues must be considered, such as the Stormont House Agreement, the administration review in health and social care, the unscheduled care taskforce, contract negotiations for consultants and junior doctors, and the shape of training project, amongst other public policy initiatives.

BMA Northern Ireland urges our politicians to stop playing games with the NHS in Northern Ireland and listen to, and engage with, doctors working on the front line of healthcare. Only then will we secure the health and social care system that is fit for purpose for the 21st Century.

ENDS