Written Ministerial Statement

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Department of Health

DEPARTMENT OF HEALTH PROPOSALS ON A DUTY OF CANDOUR BILL FOR NORTHERN IRELAND

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Mr Nesbitt (The Minister of Health): I would like to update Members on my Department's work to strengthen openness, transparency, and accountability across our health and social care system.

I have previously made clear my support for an Organisational Duty of Candour in Northern Ireland, aligned with the statutory frameworks already in place across other UK jurisdictions. This would place a legal obligation on health and social care organisations to act with honesty and transparency when things go wrong, and to ensure that patients and families are informed promptly, compassionately, and accurately.

I have considered the feedback from the Being Open / Duty of Candour consultation that ended in March of this year, and there was clear support for such alignment in Northern Ireland regarding Organisational Duty of Candour. I want to bring this legislation forward as soon as possible and I have tasked officials with developing a Bill - targeting this mandate. This approach reflects our shared ambition to further embed a culture of openness and learning, while ensuring alignment with the rest of the UK.

Importantly, alongside the development of this Bill, my Department has continued to work with other NI Departments and Whitehall Departments on the development of the Public Office (Accountability) Bill that was published earlier this week. This proposed UK-wide Bill would legally require all public officials – including those working in healthcare - to act in the public interest with candour, frankness, and transparency. Further work will be needed in the coming weeks and months to ensure that the Bill delivers for Northern Ireland.

Aligning Northern Ireland with the rest of the UK in terms of Duty of Candour brings several strategic, operational and cultural benefits to the health and social care system. Consistency in terms of duty of candour across the jurisdictions within the UK, will help to enhance and build on existing professional regulation systems and standards which are largely governed on a UK-wide basis.

Alignment across the UK not only enables greater learning from the experiences elsewhere, helping us avoid common pitfalls and adopt best practice, but also strengthens workforce support and engagement by fostering a shared sense of purpose and accountability. When staff across jurisdictions operate within an aligned legal and ethical framework, it enhances clarity around obligations, duties and consequences; helping promote consistency of approach and fairness. Furthermore, a unified approach supports more efficient rollout of initiatives, streamlines training, and encourages collaboration across borders. This collective approach helps build a stronger, more resilient workforce, better equipped to deliver safe, high-quality care.

Whilst progress legislatively is important, I am also very clear that improving culture is also a fundamental part of creating and maintaining safer services and delivering better outcomes for our patients. Key to these efforts is the forthcoming Being Open Framework that my department is due to publish in the coming months.

This Framework is being designed to ensure that individuals within our health and social care system are fully empowered to exercise candour and openness, and that HSC organisations have in place the necessary support and systems required to enable and to nurture a truly open culture.

The combination of these two Bills will not only align the HSC with similar arrangements throughout the UK, but with our Being Open Framework, will help further embed an open, just and learning culture in Northern Ireland.

Another key element of my Department's policy agenda to support and enable cultural change is the ongoing review of our Serious Adverse Incident procedure. A key aim of the review is to design a new process which is streamlined and simplified to help conclude learning reviews in a timelier manner – and to deliver a new process which has a focus on systems based learning and improvement; supporting a move away from a culture of blame to one of compassion, psychological safety, and just and balanced accountability. This is key to support all those involved in patient safety incidents and to identify and embed learning more quickly to improve services and help minimise reoccurrence. My Department is currently undertaking a detailed analysis of the consultation responses, with a Consultation Response Report to be published in November 2025, followed by a managed transition phase.

It is very important to be clear on the underpinning policy objective across all work in this space – centred on improved patient safety. When our healthcare staff are candid, frank and transparent when things go wrong and are supported to be so – we improve patient safety. And when we implement and enhance systems designed to encourage such openness – we improve patient safety. This openness also strengthens accountability and can help to rebuild public confidence in our health and social care services, reinforcing the trust that is essential to safe and effective care.

This is a significant, ambitious and necessary body of policy and legislative work aimed at improving patient safety, enhancing accountability and building public confidence in the way we provide our services. This serves to underline my commitment and indeed our shared commitment across the HSC, in this critical area.

By taking these actions, we address a number of the findings arising from the Inquiry into Hyponatraemia Related Deaths, the Independent Neurology Inquiry and the more recent Infected Blood Inquiry; and delivering on several commitments set out in the HSC Reset Plan.