SECTION 1. WHAT ACTION IS THE WELSH GOVERNMENT CONSIDERING AND WHY?

Background

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 received Royal Assent in June 2020. It contains four main parts, one on which places a statutory duty of candour on NHS bodies in Wales. It is intended to bring the duty into force from April 2023.

The duty supports the further development of an open and honest culture across NHS Wales which drives learning and improvements to services. It builds on the principle of Being Open at the heart of Putting Things Right, the process for handling concerns in NHS Wales.

Health care professionals have an *individual* professional duty of candour which requires them to be open and honest with patients where there have been failings in their care. The *organisational* duty complements the individual duty.

The duty builds on work to develop a culture of openness in Wales and will place a duty on organisations to follow a set procedure, underpinned by statutory guidance.

LONG TERM

A positive long-term impact of the duty will be the further enhancement of an open and honest culture, building on previous developments as evidenced in research by Professor Graham Martin[1], [2] which indicates that the duty has been effective in improving openness in NHS England. An evaluation by the Scottish Government in 2020[3] acknowledged progress.

Biermann & Boothman (2006)[4] state that disclosure is linked to improving patient safety which will encourage learning and may act as an incentive for reducing incidents.

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[1] Martin, G. P., Chew, S. and Dixon-Woods, M. (2019) Senior stakeholder views on policies to foster a culture of openness in the English National Health Service: a qualitative interview study (sagepub.com). Journal of the Royal Society of Medicine, Vol112(4) 153-159

[2] Martin, G., Chew, S. and McCarthy, I. (2022) Encouraging openness in health care: Policy and practice implications of a mixed-methods study in the English National Health Service - Graham Martin, Sarah Chew, Imelda McCarthy, Jeremy Dawson, Mary Dixon-Woods, 2023 (sagepub.com). Journal of Health services Research & Policy, Vol 28, issue 1. https://journals.sagepub.com/doi/10.1177/13558196221109053

[3] Jamieson, M. K (2020) Organisational duty of candour procedure: first year review - gov.scot (www.gov.scot)

[4] Biermann, J. S., & Boothman, R. (2006). There Is Another Approach to Medical Malpractice Disputes | JCO Oncology Practice (ascopubs.org), vol 2(4), 148

The duty will support and empower staff to be open with patients, strengthening the relationship between NHS bodies, their patients and communities and leading to better patient experience.

COVID-19, underfunding of the NHS, the workforce and the cost-of-living crises may add pressure on the NHS and lead to longer waiting lists. This impact has been mitigated by acknowledging that only unexpected or unintended harm on waiting lists could trigger the duty.

PREVENTION

The duty fits with the core value of 'A Healthier Wales,' putting quality and safety above all else. It aims to create a consistent process to ensure patients are treated in an open, honest, and equitable manner, whilst promoting learning and improvement to prevent recurrence.

Incidents will be investigated through the Putting Things Right process, ensuring learning and improvement, and breaking the negative cycle of poor health caused by harm.

Learning shared within the organisation and more widely will improve services, prevent recurrence, and improve patient safety across Wales. NHS bodies will be required to report annually on compliance with the duty and publish reports.

INTEGRATION

The well-being objectives in Programme for Government 2021 to 2026 have been considered. The proposal meets the objective to provide *effective, high quality and sustainable healthcare*.

The proposal fits with the aims of engagement and transparency in 'A More Equal Wales' by listening to and working with patients to ensure learning.

The proposal will benefit socio-economically disadvantaged people who are more likely to access healthcare and have the most to gain from the duty.

COLLABORATION AND INVOLVEMENT

The duty of candour was developed with stakeholders throughout NHS Wales and the UK. Representatives from professional networks across NHS Wales provided professional advice, support, informing and influencing their networks.

Efforts were made to engage with patients, their representatives, Black, Asian and Minority Ethnic people, children and young people and learning disability groups through virtual workshops.

All stakeholders were clear in their support for an organisational duty of candour and furthering the principles of being open and transparency.

IMPACT

The proposal will have a positive impact on improving honest and transparent communication, and in the long term install greater confidence in NHS services. Service users and their families want to be told when they have been affected by a patient safety incident, O'Connor et al (2010) [5].

The duty will promote a culture of being open and honest, always learning and improving which may reduce the number incidents and the lead to fewer complaints and litigation, Holden, J (2009)[6] and Fields, A et al (2021)[7].

A negative short-term impact raised by stakeholders was a potential increase in workload, particularly for primary care but it is felt this will decrease once there is understanding and confidence in the process. The impact can be countered with research by the Partnership for Responsive Policy Analysis and Research (2018)[8].

COSTS AND SAVINGS

Costs relate to the implementation of the duty of candour in NHS Wales. There will be a need for general awareness of the duty for the public and staff which will be included in a communication strategy. Training at different levels will be required to include tailored online and in-person training for all staff on the duty of candour. Costs of £153k have been allocated as directs costs for 2022-23 and 2023-24.

There may be savings in the long term through fewer complaints to process, less redress and reduced litigation.

MECHANISM

Legislation is proposed and a Regulatory Impact Assessment has been completed.

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[5] O'Connor, E., Coates, H.M., Yardley, I.E., Wu, A.W. (2020) Disclosure of patient safety incidents: a comprehensive review | International Journal for Quality in Health Care | Oxford Academic (oup.com) Vol22, Issue 5, pp371-379.

[6] Holden, J. (2009) Saying sorry is not the same as admitting legal liability | The BMJ, 338

[7] Fields, A., Mello, M., Kachalia, A. (2021) Apology laws and malpractice liability: what have we learned? | BMJ Quality & Safety

[8] Birks, Y., Aspinal, F., Bloor, K. (2018) UnderstandingDriversOfLitigationInHealthServices.pdf (york.ac.uk)