SECTION 8. CONCLUSION

8.1 How have people most likely to be affected by the proposal been involved in developing it?

The duty of candour was developed with stakeholders throughout NHS Wales and the UK, eg NHS bodies, Royal Colleges, Advisory Groups, professional networks, Commissioners, patient groups, third sector organisations, devolved administrations, and Welsh Government colleagues. NHS Wales representatives are members of the Implementation Board and Strategic Oversight Board.

A virtual focus group was held to engage with patients and their representatives including those with protected characteristics eg Black, Asian and minority ethnic groups and learning disability groups. The group provided additional contacts through their peers and networks which enabled wider engagement on the consultation.

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

Children in Wales held a small focus group with young people to discuss some aspects of the duty. Children in Wales felt that this is a complex subject for children and young people to fully understand. They agreed to provide a more focussed approach by providing feedback on the children and young people section of the guidance for staff and an awareness leaflet specifically for children and young people.

In addition, the Duty of Candour regulations and statutory guidance were subject to a 12-week public consultation advertised to all stakeholders and the public on the Welsh Government website. This consultation saw 135 response form completed with over 800 comments from a variety of stakeholders.

8.2 What are the most significant impacts, positive and negative?

The duty builds on work that has already been undertaken to develop and support the culture of openness within the NHS in Wales such as the Being Open principle in the Putting Things Right process. The duty will support those patients who have suffered more than minimal harm due to an incident. The resultant harm may lead to a longer recovery time, additional treatment, further health complications, life-changing conditions or in extreme cases, death. The proposal aims to ensure a consistent process when the duty is triggered to ensure patients and their families are treated in an open, honest, and equitable manner.

The premise of the duty is to promote a culture of openness and honesty which is widely associated with good quality care. When the duty is triggered, staff will feel supported and empowered within their organisations to be open with patients, apologise and explain the actions which will be taken to investigate the incident.

This will strengthen the NHS body's relationship and communications with its patients and the community, leading to more trust in the health service, a likely reduction in litigation against the NHS and better patient experience when people go through incidents that require candour.

It encourages organisational learning to help reduce incidents and avoidable harm to patients. It is in this way that the proposal meets the Programme for Government objective to provide *effective, high quality and sustainable healthcare*. NHS bodies will be required to report annually on compliance with the duty of candour and publish their reports. The reports will need to specify steps taken to prevent similar circumstances arising in the future.

The proposal supports action to tackle health inequalities thus meeting the *A healthier Wales* and *A more equal Wales* well-being goals of the Future Generations Act. The duty will benefit socio-economically disadvantaged people who are more likely to be ill and have underlying health conditions, for example people from deprived backgrounds, older people and those with disabilities. These groups are likely to access NHS healthcare more frequently and therefore have the most to gain from the proposal.

The positive impact of improving honest and transparent communication between the NHS and service users will, in the long term, install greater confidence in NHS services. The being open culture will encourage learning and improving in the NHS and in the long term reduce the number of cases of avoidable harm, leading to fewer complaints and litigation from service users.

A negative minimal short-term impact may be an increase in the number of incidents to be investigated through the Putting Things Right process when the duty is triggered. This could impact the NHS resources available to process and investigate cases particularly in primary care. However, it is felt this will be a short to medium term impact until the NHS gains understanding and confidence in the process.

8.3 In light of the impacts identified, how will the proposal:

- **maximise contribution to our well-being objectives and the seven well-being goals; and/or,**
- **avoid, reduce or mitigate any negative impacts?**

The proposal meets the *A healthier Wales* and *A more equal Wales* well-being goals of the Future Generations Act by supporting action to tackle health inequalities. Those who have greater interaction with healthcare services are more likely to benefit from the duty. The duty will promote equality for this group of people, for example disabled people, long term health conditions, the elderly and pregnant

people. The National Survey for Wales[1] provides evidence that older people, women, those with poorer health or a long-term condition are more likely to access healthcare than other sectors of the population.

The implementation of the duty of candour may be impacted by the implications of COVID-19 on the NHS, for example, the resultant increase in waiting lists. The proposal tries to mitigate this by stating that harm on waiting lists could potentially trigger the duty but the service user would have to have suffered unexpected or unintended harm. Deterioration of a condition whilst on a waiting list would not be unexpected. However, if the waiting list was incorrectly managed and a service user was missed from the list and the delay resulted in harm then the duty would apply as the harm would be unexpected.

Underfunding of the NHS and the workforce crisis could add further pressure on the NHS which may lead to longer waiting lists. The cost-of-living crisis could adversely affect the health of the population and the workforce and add pressure on the NHS.

A moderate negative impact may be felt in the short term by NHS staff with a potential increase in the number of incidents to be investigated through the Putting Things Right process as a result of the duty being triggered. This will impact the NHS resources available to process and investigate cases and may have a bigger impact on primary care contractors who are not currently reporting patient safety incidents to the same degree as secondary care providers. It is envisaged that this will be a short to medium term impact until the NHS staff gain an understanding and confidence in the process. It can be countered by research conducted by West, M and Coia, D[2] (2019) into Mersey Care NHS Foundation which suggests a 'Just and Learning Culture' leads to '…reduced time to conduct an investigation and reduced legal and termination costs."

A linked negative short-term impact may be staff having concerns about the need to have difficult conversations with patients, but this will be mitigated with the roll out of training, understanding and confidence in the process. It is anticipated that in the long term there will be a reduction in the number of incidents as a result of local and national learning.

8.4 How will the impact of the proposal be monitored and evaluated as it progresses and when it concludes?

The triggering of the duty will be recorded on risk management systems such as Datix Cymru. NHS bodies are required to report annually on compliance with the

[1] Welsh Government. National Survey for Wales. Available at: Hospital and GP services (National Survey for Wales): April 2021 to March 2022 | GOV.WALES

[2] West, M., Coia, D., (2019) caring-for-doctors-caring-for-patients_pdf-80706341.pdf (gmc-uk.org)

duty and publish their reports. Health boards will collate information from primary care providers to include in reports which will state how often the duty has been triggered, the circumstances and steps taken to prevent similar circumstances arising in the future.

The triggering of the duty is not recorded in NHS England or NHS Scotland so it will not be possible to compare with NHS Wales data. Comparison will be made with the number of patient safety incidents reported prior to the implementation of the duty and those reported following implementation.

In the medium term it is expected that the duty will lead to better understanding throughout NHS Wales of issues that lead to avoidable harm and relevant staff will feel empowered to make improvements to address these issues. We would also expect to see a reduction in the number of cases where there is moderate or serious avoidable harm and in the long term, fewer complaints, and litigation from service users.

An evaluation of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 which includes the duty of candour will be undertaken over a 5-year timeframe.