Duty of Candour Implementation Update April 2023

Purpose of the Presentation :

The Committee has regular updates for assurance programmed into the work plan on Health and Social Care (Quality and Engagement) (Wales) Act (2020).

Description :

- This update is to provide assurance on the progress made and the preparedness for the implementation of the Act, which came into effect on 1 April 2023.
- An update on the Duty of Candour was last presented to the Committee in February 2023, this update details progress made since then.
- This directly links with the Risk 207 on the Corporate Risk Register ('There is a risk that Public Health Wales will fail to meet the requirements of The Health and Social Care (Quality and Engagement) (Wales) Act (2020)')

Recommendation

- Consider the information provided
- Receive Assurance on the progress made and the preparedness for the implementation of the Act.

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Duty of Candour Implementation Update April 2023

- What is Duty of Candour
- Progress to Date
- Implementation Plan Update
- Governance
- Potential Risks
- Next Steps

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A Reminder : Duty of Candour

Overview

- **Duty of Candour** has being introduced in April 2023 as part of the Health & Social Care (Quality and Engagement) (Wales) Act 2020 along with the Duty of Quality.
- The overall purpose of Duty of Candour is to ensure as an NHS Wales organisation we are **open, honest and supportive** when there has been **an unintended or unexpected incident** which has **resulted or could have resulted in an adverse outcome for a service user**
- This includes telling the person affected that an unintended or unexpected incident has occurred; apologising; offering and involving them to understand what happened
- Builds on Putting Things Right (PTR) principles

Work completed and Ongoing

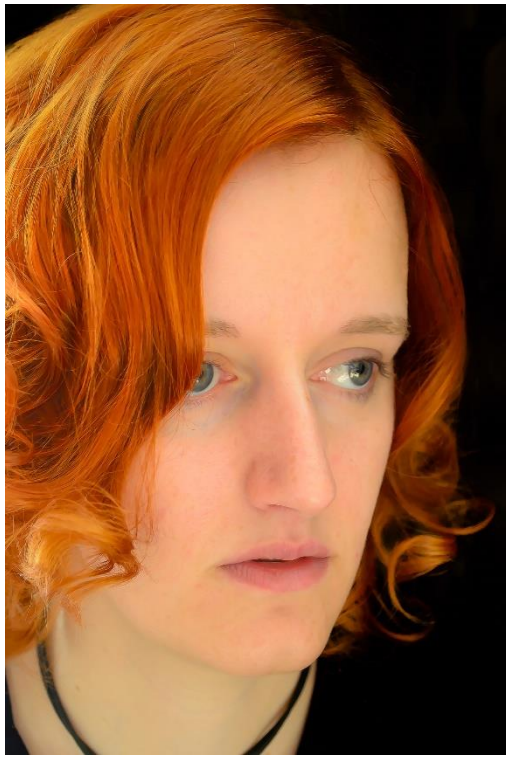
- Representation at DOC & Quality Executive Implementation Board and Network
- Monthly Submission of DOC Highlight report to WG
- Contribution to the WRP Network & Subgroup programmes
- DOC internal implementation group (QNAHPS)
- Project/Implementation plan and monitoring
- Internal Engagement sessions/ Training Workshops
- DOC policy and Procedure production
- PTR Policy and Procedures Revision
- Communications Launch with supporting materials

Key Areas of activity

Activities and status	
Policy & Procedures	✓
Staff marketing materials (Leaflets, videos, intranet page)	✓
Public marketing materials (Leaflets, videos, internet presence)	✓
Letter Templates	✓
Training & training materials	✓
Process changes & Governance mechanisms	

DOC Application Examples

A Cervical Screening Programme Participant diagnosed via the symptomatic services with a cervical cancer between negative screening episodes



- A Cervical Screening Wales audit reveals that two prior cervical screening slides should be upgraded from negative results to High Grade Dyskaryosis (pre cancerous changes that affect the full thickness of the cervix surface).
- A 5 year delay between the first misinterpreted slide and the date of diagnosis.

Outcome *Unexpected/ unintended harm*:-

- Had the High Grade Dyskaryosis been categorised when the screening slide was first considered, the Programme Participant's cervical cancer could have been identified sooner, preventing the development of cervical cancer which could have adversely impacted the Programme Participant's prognosis, treatment pathway and life expectancy.

Categorisation of harm:-

Severe Duty of candour applies

DOC application example 2

A Microbiology Case

- A testing error occurred in the laboratory whereby a blood culture was incorrectly categorised as negative for sepsis when the sample was actually positive.
- The patient had sepsis and did not receive antibiotic treatment following the reported negative result.
- The patient deteriorated and Health Board colleagues reverted back to the laboratory for reassurance of the outcome of the test. Re-testing demonstrated that the blood culture was positive for sepsis and appropriate antibiotics prescribed and administered.

Outcome: *Unexpected/ intended harm*
Increased length of stay in hospital by 4-15 days which could have been avoided had the antibiotics been administered at the earliest opportunity with the correct blood culture result.

Categorisation of harm
Moderate Duty of Candour applies

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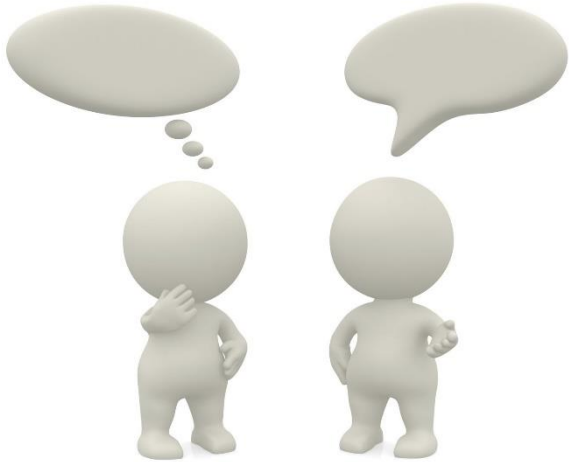
Engagement Activity

- Training Workshops held with Screening Divisions, Microbiology and Health Protection.
- Dates scheduled for Quarter 1 and beyond
- Bespoke sessions continue on request and DOC engagement events



Potential Risks & Concerns

Risks or Concerns	Mitigation
Workforce: DOC knowledge and skills and application of DOC	Awareness raising though a communications plan, launch and supporting materials Targeted education workshops Newsletters WG Materials including leaflets, awareness video, ESR eLearning module launched Assignment of ESR DOC module to role specifici training for identified staff (underway) PHW bespoke level 2 in house training offer
Workforce Demand: staff may not be able to meet the extra workload required by DOC investigations and follow up in person meetings	Local Service monitoring of demand and capacity and impact on performance Risk Register with monitoring /review
Impact of front line service delivery from the additional DOC requirements	As Above

Potential Risks & Concerns cont.

Risks or Concerns	Mitigation
Workload pressures may contribute to DOC breaches or DOC backlogs	Local Service monitoring of demand and capacity and impact on performance PTR team oversight and monitoring of incidents and performance and application of DOC Policy and Procedure PTR oversight of all incidents
BTW- concerns regarding the impact on the interval cancer audits backlog	Local Monitoring, and management of workforce and audits Baseline assessment of impact completed using current data
Increased costs initially but anticipated improvements for learning from DOC	PTR oversight and monitoring of DOC redress and PTR claims

Estimated Resource Implications from DOC application

A review of Datix incident investigations completed between 1.4.22 and 31.3.23 indicate a total of 50 moderate and above harm events within PHW

It is estimated that each case if DOC were applied would require an extra 4 hours in addition to the investigation time and resource

Estimated additional hours/resources = **200 hours**

Next steps

GOVERNANCE

PUBLISH POLICIES & PROCEDURE

CONTINUE REPORTING TO WG

TRAINING

CONTINUE TRAINING WORKSHOPS

ASSIGN DOC COMPETENCY TO ESR RECORDS

MONITOR

DOC TRAINING UPTAKE & COMPLIANCE

IMPLEMENTATION

REVIEW INCIDENTS AND APPLICATION OF DOC RESPONSES

LEARNING

STRENGTHEN LEARNING AND SHARING OF DCO CASES

OVERSIGHT & SUPPORT

SUPPORT SERVICES WITH DOC PROCESSES

REPORTING AND MONITORING

COLLATION OF DATA , TRIANGULATION OF DATE AND SUBMISSION OF REPORTS

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