GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	10 June 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Duty of Candour Annual Report: How we met the Duty of Candour in 2024/2025
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sharon Daniel, Executive Director of Nursing, Quality and Patient
SWYDDOG ADRODD: **REPORTING OFFICER:**	Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

All NHS organisations are required to publish an Annual Duty of Candour Report as part of the organisation's annual reporting process.

The purpose of this report is to share with the Quality, Safety and Experience Assurance Committee the current draft *Duty of Candour* Annual Report for 2024 to 2025 (appendix 1).

Cefndir / Background

The Quality and Engagement Act became law on 1 June 2020 and came into force on 1 April 2023.
The Act:

- Ensures that NHS bodies and ministers think about the quality of health services when making decisions;
- Ensures NHS bodes and primary care services are open and honest with patients, when something may have gone wrong with their care; and
- Creates a new Citizen Voice Body to represent the views of people across health and social care.

There are two main duties under the Act which the Health Board must consider.

The Duty of Quality
Quality is more than just meeting service standards; it is a system-wide way of working to provide safe, effective, person-centred, timely, efficient, and equitable care in the context of a learning culture. To help achieve this, the Act:

- Places an overarching duty of quality on the Welsh Ministers; and
- Reframes and broadens the existing duty on NHS bodies.

This ensures the concept of "quality" is used in its broader definition, not limited to the quality of services provided to an individual or to service standards.

NHS bodies are placed under a duty to report on the steps they have taken to comply with the duty of quality on an annual basis.

The Duty of Candour
A culture of openness, transparency and candour is widely associated with good quality care. To help achieve this, the Act places a duty of candour on providers of NHS services (NHS bodies and primary care) – supporting existing professional duties.

The duty requires NHS providers to follow a process when a service user suffers an adverse outcome which has or could result in unexpected or unintended harm that is more than minimal, and the provision of health care was or may have been a factor. There is no element of fault, enabling a focus on learning and improvement, not blame.

The duty seeks to promote a culture of openness and improves the quality of care within the health service by encouraging organisational learning, avoiding future incidents.

Under the duty, NHS Bodies will be required to report annually on compliance with the duty and publish their reports. Local Health Boards will be required to collate this information from those primary care providers with whom they enter into a contract or arrangements for services and publish a combined report.

When reporting, NHS Bodies will be required to specify if the duty of candour has been triggered in the reporting year (defined as each period of 12 months ending on 31st March, (each financial year), and if it has:
1. state how often the duty of candour has been triggered during the reporting year.
2. give a brief description of the circumstances in which the duty was triggered; and
3. specify any steps taken by the body with a view to preventing similar circumstances from arising in the future.

The report must be prepared as soon as practicable after the end of each financial year.

Asesiad / Assessment

Preparation of the Duty of Candour Annual Report
Duty of Candour data within DatixCymru was also validated and information gathered in preparation for the report.

Attached as appendix 1, is the proposed annual report for 2024/25.

Developing Always on Reporting
Information on the duty of candour and duty of quality has been provided regularly to QSEC through the quality assurance report. It is proposed that this regular reporting mechanism continue.

Next Steps
The finalised Duty of Candour annual report will be presented to the Annual General Meeting in September 2024.

Argymhelliad / Recommendation

The Quality, Safety and Experience Assurance Committee is asked to:

- Provide comment on the draft report for 2024/25
- Note and support the proposed next steps.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.22 Monitor progress of and assure the Board in relation to its compliance with relevant healthcare standards and duties, national practice, and mandatory guidance.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	No corresponding risk identified on organisational risk register
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply Choose an item. Choose an item. Choose an item.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply Choose an item. Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply Choose an item. Choose an item. Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	DatixCymru EQIiP Programme
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiad: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	This annual requires resource in the form of staff time to produce it. This comes principally from the Director of Nursing, Quality and Patient Experience's budget. Resource will also be required from other areas such as Communications.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	This annual report reports on the quality of HDdUHB services to the public, and is an important part of the Health Board's Annual Reporting process.
Gweithlu: **Workforce:**	Development of staff through pooling of skills and integration of knowledge
Risg: **Risk:**	This annual report as reputational risks if it is not published, or if the information within it is inappropriate or inaccurate. These are mitigated through review by Committees/Groups of the Health Board and by the Board Secretary, as well as audit by Internal Audit.
Cyfreithiol: **Legal:**	This annual report has legal risks if it is not published, or if the information within it is inappropriate or inaccurate. These are mitigated through review by Committees/Groups of the Health Board and by the Board Secretary, as well as audit by Internal Audit.
Enw Da: **Reputational:**	This annual report has reputational Risks if it is not published, or if the information within it is inappropriate or inaccurate. These are mitigated through review by Committees/Groups of the Health Board and by the Board Secretary, as well as audit by Internal Audit.
Gyfrinachedd: **Privacy:**	N/A
Cydraddoldeb: **Equality:**	This annual report reports on services only. It aims to cover as many areas of service as possible, but it is not possible to cover everything within the report.

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Duty of Candour Annual Report

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How we met the Duty of Candour between April 2024 and March 2025

Welcome from the Chair of the Quality, Safety and Experience Committee and Executive Director of Nursing, Quality and Patient Experience

We are delighted to bring you this report for 2024 to 2025 which shows how we, Hywel Dda University Health Board (the Health Board), are fulfilling our requirements under the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act) to meet the Duty Candour.

This report provides you with a summary of what is in place to ensure the Health Board is able to meet its obligations under the Act in relation to the Duty of Candour, how often the Duty has been triggered and what the themes are.

We continuously monitor our systems and processes so that we can learn and improve to ensure safe and high-quality care. We welcome your feedback in the form of complaints, concerns and compliments and provide a variety of ways in which you can do that. We work together with Healthcare Inspectorate Wales and Llais who give us independent feedback in light of visits to the Health Board and ensure that we act upon their recommendations.

Anna Lewis, Independent Member – Community and Chair of the Quality, Safety and Experience Committee

Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience

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The Health and Social Care (Quality and Engagement) (Wales) Act 2020

Welcome to our Duty of Candour Annual Report for 2024 to 2025. This report is intended for our population, as well as our Board. It gives us the opportunity to share with you how we are fulfilling our requirements under Duty of Candour which is a statutory duty within the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act).

The Health and Social Care (Quality and Engagement) (Wales) Act became law on 1 June 2020 with its full implementation completed April 2023. Its intention is to:

- Ensures that NHS bodies and ministers think about the quality of health services when making decisions;
- Ensures NHS bodes and primary care services are open and honest with patients, when something may have gone wrong with their care; and
- Creates a new Citizen Voice Body to represent the views of the people across health and social care.

There are two main duties under the Act which the Health Board must consider.

The Duty of Quality

Quality is more than just meeting service standards; it is a system-wide way of working to provide safe, effective, person-centred, timely, efficient and equitable health care in the context of a learning culture.

Significant progress has been made to improve the quality of health services in Wales but we still have challenges and changes that we must make to achieve better outcomes for patients across Carmarthenshire, Ceredigion, Pembrokeshire and the borders.

The Duty of Candour

The key intention of the Duty of Candour is to promote a culture of openness, learning and improving that is owned at organisational level, whether a person receives care from the NHS, or from a regulated provider of health care services, and that person can be assured that they will be dealt with in an **open and honest** way by their care provider.

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Meeting the Duty of Candour: how we are ensuring we are open and transparent

The Health Board recognise the importance of the Duty of Candour in promoting a culture of openness and ensuring that there is learning and improving that is owned at organisational level.

Even when the Health Board does its very best to prevent harm, people may experience harm. This is why the duty of candour is in place. If the care provided has caused moderate harm, severe harm or death to a patient, this means that the organisations health and care professionals must tell its patients or someone acting on their behalf that harm has been caused.

By being open and honest, it will give people confidence and trust in the care and treatment they received from the Health Board.

Organisational Requirements

NHS bodies are required to follow a procedure when the duty of candour is triggered. The Act also requires NHS providers to report annually about when the duty has come into effect, how often the duty has been triggered, a description of the circumstances leading to the event and the steps taken by the provider with view to preventing any further occurrence. Triggering the duty does not mean an NHS body accepts any fault or blame.

Triggering the Duty of Candour

The Duty of Candour comes into effect if it appears to the NHS body that both of the following conditions are met:

- The first condition is that a person (the 'service user') to whom health care is being, or has been, provided by the body has suffered an adverse outcome which is more than minimal harm;
- The second condition is that the provision of the health care was, or may have been, a factor in the service user suffering that outcome.

For the purpose of the first condition, a service user is to be treated as having suffered an adverse outcome if the user experiences, or if the circumstances are such that the user could experience, any unexpected or unintended harm that is more than minimal.

The Duty of Candour Statutory Guidance 2023[1] prescribe the actions that must be taken and supports the existing processes for 'Putting Things Right' (the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011) with updates made to the Putting Things Right' (PTR) Regulations to include the Candour Guidance.

[1] https://www.gov.wales/sites/default/files/publications/2023-03/duty-of-candour-statutory-guidance.pdf

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More than minimal harm

"More than minimal harm" is not defined in the Act. However, for the purposes of this guidance "more than minimal harm" is considered to constitute moderate harm, severe harm and death.

Moderate harm: is any significant but not permanent harm or harm that requires a 'moderate increase in treatment' relating to the incident. A moderate increase in treatment is defined as an unplanned return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient or transfer to another treatment area such as intensive care Severe harm: is the permanent lessening of the bodily, sensory, motor, physiologic or intellectual functions, including the removal of the wrong limb or organ or brain damage, which is related directly to the incident and not related to a natural course of the service user's illness or underlying condition.

Death: A death caused or contributed to by a patient safety incident, as opposed to a death which occurs as a direct result of the natural course of the patient's illness or underlying condition

Harm that is 'unintended' or 'unexpected

For Duty of Candour to be triggered, the harm must be unintended or unexpected. It can be as a result of either an actual intervention/treatment, or an omission in care, for example, a missed cancer diagnosis.

Medical or surgical treatment and all care interventions may of course come with inherent risks or may in itself cause a temporary increase in symptoms.

Harm which is caused by the treatment itself (e.g. impairments in function as a result of surgery,) would not necessarily be notifiable. These may fall into the category of a known risk, which may have been explained to, and accepted by, the patient as part of the consenting process.

How are we assessing patient safety incidents

Each directorate and service have processes to manage patient safety incidents. This includes an initial review by a designated manager of the incident report. If a patient safety incident is categorised, by the manager undertaking the initial review of the report, as moderate or above and health care was, or may have been, a factor, the Duty of Candour is triggered, and the procedure must be followed. The Datix Cymru system is used to record all activity relating to the patient safety incident including key dates relating to the Duty of Candour.

Dashboards are available within the Datix Cymru system for each directorate and service to ensure the Candour procedure is followed and performance indicators are met.

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Candour performance is validated by the Quality Assurance and Safety Team and is reported through the Directorate Improving Together meetings.

We would like to take this opportunity to thank our staff who strive for improvements to the quality of care provided to our patients, who continue to be open and honest and learn from concerns when things do not go as well as we would wish. Staff have embraced the Duty of Candour and are aware of the processes to comply with the requirements of the Act. There is further work to do to support staff to comply in a timelier manner with the reviews and responses to concerns, and we are committed to make improvements in this area.

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Health Board Performance

During 2024/2025[2], 2,247 patient safety incidents were reported where the reporter said their initial harm assessment was moderate or above. Of these incidents, following the Manager's Interim Harm Assessment, 1,688 patient safety incidents were downgraded to low harm, no harm or the incident occurred prior to the introduction of the Duty. This shows an 75% downgrade rate across the Health Board (in 2023/2024, we reported a downgrade rate of 79%).

During the reporting period, Datix Cymru is reporting as showing 132 patient safety incidents graded by the reporter as no or low harm which, following 'Manager's Interim Harm Assessment', were re-graded as moderate harm or above.

There can be a difference between the reporter's harm grading and the manager's interim harm assessment. The reporter may give the outcome for the person affected with no consideration as to whether there was an act or inaction in the healthcare or they may report on what they expect the harm will be for the person affected rather than the actual harm.

This data suggests further work is required to ensure staff are aware of the classification of harm to be record when reporting an incident.

Duty of Candour Triggered

During 2024/25, both conditions[3] were met and the duty of candour was triggered in 132 patient safety incidents[4].

The manager's interim harm assessment was recorded as moderate harm in 104 incidents, severe harm in 19 incidents and catastrophic harm / death in 9 incidents.

Moderate	Severe	Catastrophic / Death
104	19	9

The manager undertaking the initial assessment is asked to provide information as to the rationale for triggering the Duty of Candour. The high level themes are:

- In-patient slips, trip or fall (20%)

[2] *Patient safety incidents reported between 01.04.24-31.03.25 where the reporter has stated their initial assessment of harm is moderate, severe or catastrophic/death*

[3] *The Duty of Candour comes into effect if it appears to the NHS body that both of the following conditions are met:*

- *The first condition is that a person (the 'service user') to whom health care is being, or has been, provided by the body has suffered an adverse outcome which is more than minimal harm;*
- *The second condition is that the provision of the health care was, or may have been, a factor in the service user suffering that outcome.*

[4] *Patient safety incidents where the duty was triggered between 01.04.24-31.03.25*

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- Pressure Damage developed or worsened whilst receiving healthcare (11%)
- Complication of treatment (7%)
- Delay in care / treatment / procedure (17%)
- Delay in diagnosis (16%)
- Delay in referral to other professional for assessment / treatment (9%)
- Healthcare acquired infection (4%)
- Treatment / Procedural issues (5%)
- Inappropriate monitoring and / or escalation (8%)
- Medication error / delay / omission (4%)

Post investigation harm

Of the 132 patient safety incidents where the duty was triggered between 01/04/2024 and 31/03/2025, 75 incidents have been investigated and the record closed. Post investigation harm assessment shows that 25 (33%) did not cause moderate harm or above as a result of healthcare.

		Harm post investigation					
		None	Low	Moderate	Severe	Catastrophic / Death	Total
Manager's interim harm assessment	Moderate	7	14	43	2	0	66
	Severe	1	3	0	4	1	9
	Catastrophic / Death	0	0	0	0	0	0
	Total	8	17	43	6	1	75

Learning identified

Of the patient safety incidents where the duty was triggered and the investigation has concluded, the learning includes:

- Ensuring required training has been completed and competency assessed
- CT contrast must only be administered via a line that is clearly labelled as pressure injectable.
- A clear escalation policy for radiology needs to be developed
- A health board wide contrast media policy needs to be developed
- Use of cannula care bundle and recording of Visual Infusion Phlebitis (VIP) score
- Peer review of pressure damage to confirm grading.

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- Use of body map for pressure damage
- Adherence to the 'Care after a death' policy and updating to reflect recent changes to how to request portering services for transfer of deceased patient.
- Importance of environment and patient safety huddles.
- Importance of assessing overall clinical picture
- Consideration of clinical impression when reviewing radiological imaging
- Notification of senior clinician when trauma call made
- Cognitive bias and clinical assessment and diagnosis
- Importance of arranging scans and documenting appropriate management plans when women present with reduced fetal movements.
- Importance of the completion of care plans around the management of second trimester loss for patients, in line with good practice.
- Unplanned reattendances within 72 hours need to be seen by a consultant or senior registrar as this is a high-risk group (as per RCEM guidelines).
- Importance of completing NEWS correctly and escalating accordingly.
- Engagement with specialty team e.g. any problem with an overlying a graft should be referred to the vascular team and is likely to require an angiogram

Contracted Services – Primary Care

Contractors within the Primary Care setting, which includes Community Pharmacists, General Medical Practitioners, General Dental Practitioners and Optometrists, are required to submit data to the Health Board relating to the Duty of Candour in September 2025.

Concerns Management

High quality, safe and compassionate care is at the heart of health care being delivered by our staff. Despite these intentions, inevitably from time to time our patients may suffer harm due to challenging and / or complex situations. When harm does occur, being open and honest should feel like the right thing to do.

Dealing with these situations quickly, sensitively and openly is of great importance and can make a difference to a patient's ongoing relationship with the Health Board.

Throughout 2024/25 at our Board meetings, we have reported how we are improving our people's experience which includes our concerns management and patient experience survey data. An example from the Board meeting in March 2024, can be found through the following link https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2025/board-agenda-and-papers-27-march-2025/board-agenda-and-papers-27-march-2025/13-improving-people-and-community-experience-report-pdf/

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Listening and Learning Sub-Committee

The Listening and Learning Sub-Committee is a sub-committee of the Health Board's Quality, Safety and Experience Committee. The sub-committee provides clinical teams across the Health Board with a forum to share and scrutinise learning from concerns (incidents, complaints, and claims) and other quality areas such as external inspections, and to share innovation and good practice.

During 2024/25, the Listening and Learning Sub-Committee considered the following themes. This was in addition to the Learning from Events Reports (LfER)relating to Redress payments and claims and recommendations made by the Public Services Ombudsman for Wales. A summary of the Sub-committee can be found in the agenda and papers for the Quality, Safety and Experience Committee.

- Falls
- Sensory loss
- Do Not Attempt Cardiopulmonary Resuscitation
- Maternity
- Cancer experience

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