



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	11 June 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Duty of Candour Annual Report: How the Health Board met the Duty of Candour in 2025/2026
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding Caroline Burgin, Patient Safety and Assurance Manager

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 Committee (QSEC) the current draft *Duty of Candour* Annual Report for 2025 to 2026 (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 bodies 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.

Appendix 1 contains the proposed annual report for 2025/26.

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 on 30 July 2026.

Argymhelliad / Recommendation

The Committee is asked to:

- Provide FEEDBACK on the draft Duty of Candour Annual Report for 2025/26 and RECOMMEND for Board approval.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.11 Ensure that the organisation is meeting the requirements of the Health and Social Care (Quality and Engagement) Act and recommend the Annual Duty of Quality and Duty of Candour Reports to Board for approval as soon as reasonably practicable after the end of each financial year. 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
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	DatixCymru EQliP Programme
Rhestr Termiau: Glossary of Terms:	Contained within the body of the report

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofïod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	N/A
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Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The Annual Report requires resource in the form of staff time to produce it. This comes principally from the Executive 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:	The Annual Report outlines the quality of HDdUHB services provided to the public and forms 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:	The Annual Report presents reputational risks if it is not published or if its content is inappropriate or inaccurate. These risks are mitigated through review by Health Board committees and groups, the Director of Corporate Governance/Board Secretary, and Internal Audit.
Cyfreithiol: Legal:	The 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 Director of Corporate Governance/Board Secretary, as well as audit by Internal Audit.
Enw Da: Reputational:	The 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 Director of Corporate Governance/Board Secretary, as well as audit by Internal Audit.
Gyfrinachedd: Privacy:	N/A

**Cydraddoldeb:
Equality:**

The Annual Report focuses on services and aims to cover as many areas as possible, although it cannot include every aspect of service provision.



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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

DUTY OF CANDOUR ANNUAL REPORT

**How we met the Duty of Candour
between April 2025 and March 2026**

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 2025 to 2026 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.



Eleanor Marks, Vice Chair and Chair of the Quality, Safety and Experience Committee



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

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

Welcome to our Duty of Candour Annual Report for 2025 to 2026. This report is intended for our population, as well as our Board members. 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 bodies 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.



DRAFT FOR APPROVAL

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 increase 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](https://www.gov.wales/sites/default/files/publications/2023-03/duty-of-candour-statutory-guidance.pdf)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>

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 Clinical Care Group and Clinical Service Group 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.

Candour performance is validated by the Quality Assurance and Safety Team and is reported through the Clinical Service 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 and are proud 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.

DRAFT FOR APPROVAL

Health Board Performance

During 2025/2026², 1952 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, 1,352 patient safety incidents were downgraded to low harm or no harm. This shows a 69.2% downgrade rate across the Health Board (in 2024/2025, we reported a downgrade rate of 75%).

During the reporting period, Datix Cymru is reporting as showing 85 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 recorded when reporting an incident.

Duty of Candour Triggered

During 2025/26, both conditions³ were met and the duty of candour was triggered in 109 patient safety incidents⁴.

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:

- Inpatient fall (16.5%)
- Pressure Damage developed / worsened in hospital (4.5%)
- Maternity adverse event (3.6%)
- Medication issues (2.75%)

The top 5 reported categories of incidents where the Duty was triggered:

- Accident / Injury (21%)
- Treatment / Procedure (14%)

² Patient safety incidents reported between 01.04.25-31.03.26 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 01.04.25-31.03.26

- Assessment / Investigations (11.9%)
- Access / Admission (11%)
- Medication / IV fluids (11%)

Incident Classification	Number of DoC Triggered Incidents
Access, Admission	12
Accident, Injury	23
Assessment, Investigation, Diagnosis	13
Behaviour (including violence and aggression)	1
Communication	2
Equipment, Devices	1
Infection Prevention and Control	3
Maternity adverse occurrence	6
Medication, IV Fluids	12
Patient/service user death	8
Pressure Damage, Moisture Damage	10
Transfer, Discharge	2
Treatment, Procedure	16
Grand Total	109

Post investigation harm

Of the 109 patient safety incidents where the duty was triggered between 01/04/2025 and 31/03/2026, 28 incidents have been investigated and the record subsequently closed. Post investigation harm assessment shows that 7 (25%) did not cause moderate harm or above as a result of healthcare.

Of the 109 patient safety incidents where the duty was triggered between 01/04/2025 and 31/03/2026 the difference between the Interim and Post Harm is shown below:

	Managers Interim Harm Assessment	Harm Assessment Post Investigation
Moderate	75	44
Severe	24	4
Catastrophic	10	9
Low	-	10
No	-	2

Learning identified

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

- A patient contacting a practice for urgent care on three consecutive days should be offered an appointment. It is likely that the patient could have been treated successfully in a primary care setting and this scenario could have been avoided.

- Abnormal CTG patterns must be accurately classified and escalated promptly to senior clinicians.
- Fall identified promptly and family communicated with appropriately. Updates MFRA (Multifactorial Risk Assessment) and Manual handling risk assessment required after the fall. Updates to documentation regarding footwear required.
- Importance of Hover Jack and neurological observations to be documented.
- A reminder regarding the documentation of holistic care during skin checks.
- Importance of delirium screens to be documented
- Learning for inclusion in a Primary Care Briefing (Lessons Learned section) and for sharing with Secondary Care colleagues. The patient was in the incorrect area in the department and the importance of escalating any concerns regarding deterioration to be documented.
- As part of the learning from this incident, immediate action was taken to commence the development of Emergency Department–specific guidelines, policies, and clinical pathways to support consistent decision making for patients presenting with syncope. A key lesson from this case is the critical importance of early recognition and escalation of red flag features suggestive of a cardiac cause. In this instance, the patient’s presentation included exertional syncope, shortness of breath, indigestion type chest discomfort, and sudden loss of consciousness without prodromal symptoms—features which are widely recognised as high risk indicators of potential cardiac pathology but were not escalated for specialist review at the time. This incident reinforces that syncope occurring during exertion, particularly when accompanied by chest related symptoms, should prompt urgent cardiac assessment and consideration of admission or specialist referral, regardless of symptom resolution or normal findings on initial ECG and observations.
- A further learning point from this incident is the importance of timely cardiology involvement in patients presenting with high risk features suggestive of a cardiac cause of syncope. Earlier referral or admission for cardiac assessment at the point of Emergency Department attendance may have facilitated more prompt investigation of underlying cardiac pathology. The timeline also illustrates how delays to senior clinical review within a high-pressure Emergency Department environment can influence clinical reasoning. In this case, the near six-hour interval between triage and medical review may have contributed to diagnostic anchoring on a benign cause, such as vasovagal syncope, and a reduced perceived urgency for further cardiac investigation once the patient was asymptomatic.

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 2026.

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 2025/26 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 November 2025, can be found through the following link [Board agenda and papers 27 November 2025 - Hywel Dda University Health Board](#)

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 2025/26, 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.

- A&E
- Communication (Can I trust you)
- Mental Health/Learning Disabilities
- Communication & Regulatory Updates
- Ophthalmology