

DUTY OF CANDOUR

ANNUAL REPORT

**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

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 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.



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](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 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.

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.

Health Board Performance

During 2024/2025², 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 conditions³ were met and the duty of candour was triggered in 132 patient safety incidents⁴.

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%)
- Pressure Damage developed or worsened whilst receiving healthcare (11%)

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

- 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.
- 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/>

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