Hywel Dda University Health Board Duty of Candour Annual Report

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

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

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1. Welcome

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 that shows how we, Hywel Dda University Health Board, are fulfilling our responsibilities under the Health and Social Care (Quality and Engagement) (Wales) Act 2020 to meet the Duty Candour.

Our report provides a summary of what is in place to ensure we meet our obligations under the Act as part of the Duty of Candour. We also include information on 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 continue to improve and ensure safe and high-quality care.

We work together with Healthcare Inspectorate Wales and Llais who give us independent feedback following their visits to the Health Board and ensure that we act upon their recommendations.

We welcome your feedback – whether it is a complaint, concern, or a compliment. There are a variety of ways in which you can do that.

Eleanor Marks
Health Board Vice Chair and Chair of Quality, Safety and Experience Committee

Sharon Daniel
Executive Director of Nursing, Quality and Patient Experience

2. Introduction - the Health and Social Care (Quality and Engagement) (Wales) Act 2020

This report is intended for everyone living and using our services in Hywel Dda. It is also a report for our Board.

It is an 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 Act became law on 1 June 2020 with its full implementation completed April 2023. Its intention is to:

- ensure that NHS bodies and ministers think about the quality of health services when making decisions
- ensure NHS bodes and primary care services are open and honest with patients, when something may have gone wrong with their care; and
- create 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 that the Health Board must consider.

The Duty of Quality

Quality is more than just meeting service standards. Quality 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 who access our services from across Carmarthenshire, Ceredigion, Pembrokeshire and neighbouring areas.

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, they can be assured that they will be dealt with in an **open and honest** way by their care provider.

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

We 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 organisation's 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 us as the Health Board.

Organisational requirements

NHS bodies need 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:

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

For 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] describe 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 that 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 because 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 cause a temporary increase in symptoms.

Harm that 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

Within Hywel Dda, 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.

Thank you to 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 making improvements in this area.

4. How we are performing as a Health Board

During 2025/2026[2], 1,952 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 an 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 the 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 more work is needed to ensure staff are aware of the correct classification of harm to be recorded when reporting an incident.

Triggering of the Duty of Candour

During 2025/26, both conditions[3] were met and the Duty of Candour was triggered in 109 patient safety incidents[4].

The manager undertaking the initial assessment is asked to provide information why the Duty of Candour was triggered. 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 five reported categories of incidents where the Duty was triggered were:

- Accident / Injury (21%)
- Treatment / Procedure (14%)
- Assessment / Investigations (11.9%)
- Access / Admission (11%)
- Medication / IV fluids (11%)

[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*

Incident classification	Number of Duty of Candour 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
Total	**109**

Post investigation harm

Of the 109 patient safety incidents where the Duty was triggered between 1 April 2025 and 31 March 2026, 28 incidents have been investigated and the record closed as a result. Post investigation harm assessment shows that seven (25%) did not cause moderate harm or above because of healthcare.

For the 109 patient safety incidents where the Duty was triggered between 1 April 2025 and 31 March 2026 the difference between the Interim and Post Harm is shown below:

Level of harm	Manager's Interim Harm Assessment	Harm Assessment Post Investigation
Moderate	75	44
Severe	24	4
Catastrophic	10	9
Low	-	10
No	-	2

Learning identified

We are committed to learning from patient safety incidents to make sure that they do not happen again. 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 Cardiotocography (CTG) patterns must be accurately classified and escalated promptly to senior clinicians.
- Fall identified promptly and family communicated with appropriately. Updates Multifactorial Risk Assessment (MFRA) 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 that 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 Electrocardiogram (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

The Duty of Candour also applies to our contractors in the Primary Care setting. This includes Community Pharmacists, General Medical Practitioners (GP), General Dental Practitioners and Optometrists. Our Primary Care contractors are required to submit data to the Health Board relating to the Duty of Candour in September 2026.

5. Managing your concerns

High quality, safe and compassionate care is at the heart of health care being delivered by our staff. Despite our best intentions, unfortunately 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 wellbeing and their ongoing relationship with the Health Board.

Throughout 2025/26 at our Board meetings, we have reported how we are improving our people's experience. This includes our concerns management and patient experience survey data. An example from the Board meeting in November 2025 can be found on our webpage: hduhb.nhs.wales/about-us/your-health-board/board-meetings-2025/board-agenda-and-papers-27-november-2025/board-agenda-and-papers-27-november-2025/17-strengthening-quality-governance-through-integrated-experience-reporting-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). It also includes discussion of 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.

- Accident and Emergency (A&E)
- Communication (Can I trust you)
- Mental Health/Learning Disabilities
- Communication and regulatory updates
- Ophthalmology

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 on our website: Quality, Safety and Experience Committee (QSEC) - Hywel Dda University Health Board

6. Further information

More information about the Quality and Engagement Act can be found on our website: https://hduhb.nhs.wales/quality-and-engagement-act/

If you would like to share your experience with us, you can do so by contacting our patient support services team:

Telephone: 0300 0200 159

Email: hdhb.patientsupportservices@wales.nhs.uk

Online: Using our feedback form (opens in new tab)

Post: Freepost Feedback @ Hywel Dda