

 <p> <b>GIG</b>      CYMRU  <b>NHS</b>      WALES   </p> <p>     Iechyd Cyhoeddus      Cymru      Public Health      Wales   </p>	<p> <b>Name of Meeting</b>        Quality, Safety and Improvement Committee     </p> <p> <b>Date of Meeting</b>        04/06/2026     </p> <p> <b>Agenda item:</b>        4.3     </p>
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<p> <b>Duty of Candour Annual Report</b>  <b>(1 April 2025 – 31 March 2026)</b>  <b>Confidential</b> </p>	
<p><b>Executive lead:</b></p>	<p>Claire Birchall, Executive Director of Quality, Nursing and Integrated Governance</p>
<p><b>Author:</b></p>	<p>Jacqui Westmoreland- Quality, Safety and Putting Things Right Manager.</p>

<p><b>Approval/Scrutiny route:</b></p>	<p>Business Executive Team – 06/05/2026</p>
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<p> <b>Purpose</b>        To present the annual Duty of Candour Report for 2025/26 and provide assurance that Duty of Candour incidents are being managed in line with the Duty of Candour legislation.     </p>
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<p> <b>Recommendation:</b> (note - to mark an x in the grey box below right click on the mouse, then select “properties”, and then select “checked”)     </p>				
<p>APPROVE</p> <input type="checkbox"/>	<p>CONSIDER</p> <input type="checkbox"/>	<p>RECOMMEND</p> <input type="checkbox"/>	<p>ADOPT</p> <input type="checkbox"/>	<p>ASSURANCE</p> <input checked="" type="checkbox"/>
<p>The Committee is asked to:</p> <ul style="list-style-type: none"> <li>• <b>Note</b> the content of the report and learning from the 2 DOC cases</li> <li>• Take <b>Assurance</b> that PHW Duty of Candour cases are being managed in accordance with regulatory guidance and the relevant policies and procedures, including organisational learning.</li> </ul>				

**Link to Public Health Wales Strategic Plan**

Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities and well-being objectives.

This report contributes to the following:

<b>Strategic Priority/Well-being Objective</b>	All Strategic Priorities/Well-being Objectives
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**Summary impact analysis**

<b>Equality and Health Impact Assessment</b>	An Equality Health Impact Assessment is not required
<b>Risk and Assurance</b>	Public Health Wales has a legal duty of care towards service users, staff and members of the public, who come in to contact with the services it provides.  The Duty of Candour Policy describes how incidents must be managed where the level of harm is being considered as moderate or above and service users contacted, in order to comply with our statutory obligations.
<b>Health and Social Care (Quality and Engagement) (Wales) Act</b>	The application of the Duty of Candour creates an open learning culture that person centred approach for those who are affected when things go wrong. Its application improves patient safety and the delivery of effective health care.
<b>Financial implications</b>	The financial implications relating to cases where the Duty of Candour has been triggered are detailed within the Claims and Redress reports.
<b>People implications</b>	Any learning relating to any concerns is shared via Senior Management Team meetings for awareness, discussion and wider sharing.

## **1. Purpose / situation**

This annual report provides information and provides assurance to the Quality, Safety, and Improvement Committee pertaining to Duty of Candour activity, between 1<sup>st</sup> April 2025 and 31<sup>st</sup> March 2026.

## **2. Background**

The statutory organisational Duty of Candour (DOC) came into from 1<sup>st</sup> April 2023 for all NHS Organisations in Wales as part of the Health and Social Care Act (2020). It requires NHS Organisations to be open and transparent with service users affected by unexpected or unintended harm that is assessed as more than minimal so they understand what has happened, receive an apology, and are informed of any learning and how improvements will be made for the future.

All incidents reported via the Datix Incident Management System are reviewed to ensure the appropriate application of the Duty of Candour if triggered and are managed with advice and support from NHS Wales Shared Service Partnership, Legal and Risk Services as required. For the year 1<sup>st</sup> April 2025 to 31<sup>st</sup> March 2026, 2091, incidents were reported within Datix. Out of these, 2 required the application of the Duty of Candour. All Duty of Candour incidents are proactively managed and analysed to ensure that learning is identified, and changes are implemented to improve services and reduce the risk of future reoccurrence.

An important part of this Duty is the publication of an Annual Report which describes how Public Health Wales (PHW) has implemented the Duty of Candour procedure and identified any learning from the previous year.

## **3. Description/Assessment**

This report details the number of Duty of Candour cases since 1<sup>st</sup> April 2025. It highlights the progress made and demonstrates how any identified learning has been shared within Public Health Wales Services and subsequent improvements made.

#### 4. Application of the Duty of Candour

The legislative requirements of the Duty of Candour (DOC) are to notify the person affected that a candour adverse event has occurred and provide an apology.

The below table details the DOC cases that have occurred during the period of **1<sup>st</sup> April 2025 – 31<sup>st</sup> March 2026**.

**Table 1**

	No. of Cases
Confirmed Duty of Candour cases	2

Further fundamental aspects of the regulation relate to communicating with the patient or family using their preferred method of communication and offering to meet with them to discuss the event further, providing further explanation if required and to answer any questions.

Table 2 details how the process was applied to the 2 events which are fully documented within the Datix system

**Table 2**

No.	Has the person or their family been notified	Method of Communication	Offer in person meeting accepted
1 <sup>st</sup> Case	Yes	Written- unable to make verbal contact	No
2 <sup>nd</sup> Case	Yes	Verbal	Yes

The following table details the criteria which triggered the application of the Duty of Candour in each of the cases.

**Table 3**

Date DOC triggered	Detail	Nature of Unexpected or Unintended incident where Duty of Candour applies	Service Area
14/07/2025	False negative assessment of mammograms.	Participant had a delayed cancer diagnosis	Breast Test Wales
04/08/2025	False positive result. Patient given oral antibiotics and an increased length of stay which was greater than 4 days.	An increase in individual length of stay.	Infection Services

### 5. Identified learning and actions:

Following investigation, the identified learning from both these cases were shared with the relevant services to support service improvement and staff development.

#### Breast Test Wales Case:

Anonymised findings from the review were shared across the clinical teams within the breast screening programme to disseminate learning. The learning included the need to:

- Strengthen the correlation (linking) between imaging information and pathology information at BTW Multidisciplinary discussions. Any differences should prompt a repeat biopsy sampling.
- Improve biopsy targeting documentation and procedural details at screening assessment clinics and any associated documentation.
- Quality assurance checks to confirm that calcifications are adequately sampled both from a radiography and pathologically perspective.
- Reinforcement of cautious diagnostic approach in age groups where benign new solid masses are uncommon.

#### Infection Service Case:

The incident highlighted the need for clearer, structured guidance on managing incorrect results within the laboratory environment, particularly during weekends and out-of-hours periods for laboratory staff. It also revealed that any results that are amended are not automatically flagged or identified as being amended within the current IT system, and this cannot be changed at a local level. Due to this any amended results should be risk assessed and communicated by telephone when necessary to the clinical team caring for the person. A number of recommendations and actions were identified following this investigation.

These included;

- Introduction of new digital software which checks test results. automatically removing the need for staff to do this manually.
- Ensuring that laboratory staff have access to an up-to-date email list of all the clinical staff who need to be contacted quickly.
- Updating laboratory guidance so that staff know exactly what to do if a test result is incorrect, including clear steps for evenings, weekends, and out-of-hours periods.

### **Learning from the Duty of Candour Process**

PHW ensures that staff are equipped to deal with DoC cases, by providing training and upskilling key staff in.

- how to identify, report, record and trigger the assessment process
- establish when there has been relevant level of harm that triggers a DOC
- undertake the candour and supportive action with the affected individuals/their family
- support staff involved
- approach and share learning.

Whilst there have only been 2 cases, multiple incident reviews have been undertaken applying the DoC threshold and process even though they have not triggered the application of the Duty.

### **6. Training**

Training for the Duty of Candour has been available to all staff in Wales since April 2023 as a national eLearning programme. Within Public Health Wales 328 staff were assigned this role specific competency to complete at the start of the year. Compliance is currently above target at 96% of the required staff having completed this module.

In addition to the All-Wales eLearning module, PHW developed its own bespoke training package to support managers further in their application of the Duty. To date 300 staff of 328 identified have received this training delivered by the PTR team.

PHW is an active member of the Welsh Risk Pool Candour, Learning and Safety Network which supports further learning and guidance nationally for health Boards and Trusts.

### **7. Well-being of Future Generations (Wales) Act 2015**

Not applicable as no decision is required.

### **8.0 Recommendation**

The Committee is asked to:

- **Note** the content of the report and learning from the 2 DOC cases
- Take **Assurance** that PHW Duty of Candour cases are being managed in accordance with regulatory guidance and the relevant policies and procedures, including organisational learning.