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Digital Health and Care Wales Duty of Candour – Report 2024/2025

The Duty of Candour

Openness and honesty should be at the heart of every relationship between those providing treatment and care and those experiencing it.



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THE DUTY OF CANDOUR

The Duty of Candour through the Health and Social Care (Quality and Engagement) (Wales) Act 2020 ('the Act') came into force on 1 April 2023.

The duty is required to be triggered by an NHS body if it appears to the body that both of the following conditions are met:

1. 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.
2. (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.

An adverse outcome occurs 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 (i.e. moderate harm, severe harm, and death) and also in cases where a person could experience harm (that is more than minimal) in the future.

The outcome must relate to the provision of the care by the NHS body rather than being solely attributable to the person’s illness or underlying condition.

It should be noted that “Near Miss” incidents are not considered a trigger for the Duty of Candour procedure.



DIGITAL HEALTH & CARE WALES

As a Special Health Authority Digital Health and Care Wales (DHCW) has a statutory obligation to have in place the knowledge, processes, and procedures to appropriately implement and manage the Duty.

To ensure this DHCW has apportioned responsibility for the implementation of the duty is as follows:

- Nominated Executive Lead for Candour - Executive Medical Director
- Strategic Lead - Chair of the Digital Governance & Safety Committee
- Operational Lead - Associate Director Information Governance & Patient Safety
- Day-to-day responsibility rests with the Serious Clinical Incident Investigation Manager in conjunction with Corporate Risk Manager.

All incidents are reviewed and actioned by the Patient Safety team (where required in conjunction with the Corporate Governance team), and any escalation, subsequent review of reports and learning from events is managed by the Incident Review & Learning Group (IRLG) chaired by the Chief Operating Officer, this group reports to the Digital Safety & Governance Committee.

The Duty of Candour has been included within updated Digital Health & Care Wales policies specifically the “Handling Concerns & Complaints Policy” and the “Process to Manage the Reporting and Investigation of Clinical Incidents, Risks & Concerns.”

Further detailed information in respect of the Duty of Candour has been made collated within a specific page on the [DHCW SharePoint site](#), and all relevant staff have been signposted to complete the online national training package -with completion of this mandatory for all accredited Clinical Safety Officers.

Ongoing links with the national Duty of Candour Implementation group are maintained by the Serious Clinical Incident Investigation Managers membership of this national collaborative group.

It should be noted that based upon the definitions in respect of the triggering of the Duty it is unlikely that DHCW will regularly trigger the duty, but instead it is most likely it will provide support to other NHS bodies during the process of reviewing and investigating concerns and this aligns with other existing national policies and procedures.

One of the clearest reasons for this is that DHCW is not a patient facing/care giving organisation and as such has limited ability to determine if any harm has occurred or is likely to arise in the future to a service user because of an incident.

APPLICATION OF THE DUTY

This assessment of DHCWs position is supported by the below extracts from the Duty of Candour statutory guidance.

Section 10.2

“Although not all of the bodies involved in the provision of an episode of care will necessarily be the ‘providing body’ in terms of the legislation (i.e. their provision of health care did not or does not have the potential to trigger the Duty of Candour) they may need to become involved in providing information as part of a review or providing support for the service user/person acting on their behalf.

All parties are expected to co-operate fully in an open and facilitative manner throughout the Duty of Candour procedure and share any learning identified as a result of the subsequent investigation/ review, including any actions to be taken with a view to preventing similar circumstances from arising in the future.”

Section 10.8

“If an NHS body discovers that an incident that would trigger the duty of candour procedure has occurred in a different NHS body, the NHS body that discovers the ‘incident’ should inform the NHS body where the ‘incident’ occurred, who must then implement the duty of candour procedure.

The NHS body that discovers the ‘incident’ must also be open and transparent with the service user about what they have discovered.

However, they are not required to carry out the specific duty of candour procedure; this should be carried out by the responsible NHS body, i.e. the ‘providing body’ where the duty of candour was triggered.”

OUR CURRENT POSITION

Since the implementation of the Duty of Candour in April 2023 Digital Health and Care Wales has not had to trigger the Duty nor been involved in any incidents where the care providing organisation has been triggered the Duty.

As part of the assurance framework on each occasion where, as part of an incident review, it is deemed appropriate to consider patient harm (and as a result the Duty) a clinical review/harm assessment is undertaken by the relevant NHS organisation(s) and the findings collaboratively discussed, agreed and documented by all stakeholders.