Duty of Candour Annual Report

01 April 2024 – 31 March 2025

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NHS Borders Overview

NHS Borders provides a wide range of healthcare services across multiple locations throughout the Scottish Borders. It is one of the smaller health boards in Scotland, serving a population of approximately 116,000 people across both rural and urban communities. NHS Borders employs around 3,500 staff and operates:

- One main acute hospital
- Four community hospitals
- Five mental health units
- A wide range of community teams and independent contractors

Our purpose is to improve the health and wellbeing of our population and to deliver healthcare services that meet the needs of the Borders community. Safe, person-centred care is paramount within NHS Borders.

How many incidents happened to which the duty of candour applies?

During the reporting period of 01 April 2024 to 31 March 2025 there were 138 significant adverse events graded as Extreme / Major relating to patients reported and investigated through the adverse event management process. In addition, three adverse events graded as Moderate were reported and identified as avoidable, and therefore met the criteria for DoC, totalling **141** adverse events. These were unintended or unexpected events that resulted in death or one of the harms as defined in the Act.

On final evaluation the table below shows the outcome of the review as defined by the national framework adverse event management:

Review Outcome Grading:

Review Outcome Grading criteria:	**No. of significant adverse events**
Appropriate Care (1)	11
Indirect System of Care Issues (2)	32
Minor System of Care Issues (3)	5
Major System of Care Issues (4)	1
Avoidable	30
Unavoidable	43
Still under investigation awaiting outcome grading	19
Total	**141**

During the reporting period, 36 significant adverse events were, on final evaluation, graded with a review outcome of 3 or 4, or were confirmed as avoidable events. In these cases, it was determined that if a different plan or delivery of care or service had been in place, the outcome for the patient may have been different.

An additional 19 significant adverse events remain under investigation. Until these reviews are finalised, it is not yet possible to confirm whether they meet the criteria for DoC. However, in line with best practice and organisational policy, the DoC process was activated for each of these events.

This report includes only the confirmed DoC events to date. It is recognised that further events may be added to the annual total in an addendum, once the outstanding investigations are complete.

Table 1 presents data on the 36 confirmed unintended or unexpected adverse events where, on final evaluation, it was determined that if an alternative plan or delivery of care or service had been in place, the outcome for the patient may have been different. These events met the criteria for activating the statutory DoC procedure. The table outlines the number of cases and the rationale for each:

Table 1:

Nature of unexpected or unintended incident where Duty of Candour applies	Number
The death of a person	1
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	32
Changes to the structure of the person's body	1
The shortening of the life expectancy of the person	1
An impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days	0
The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days.	0
The person required treatment by a registered health professional in order to prevent:	
The person dying	1
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	0

To what extent did NHS Borders carry out the duty of candour procedure?

The correct procedure was carried out in all instances in relation to Management Reviews and Significant Adverse Events Reviews.

The Pressure Ulcer Investigation Tool was used to review 26 adverse events which were directly in relation to Pressure Damage graded 3, 4, suspected deep tissue injury and any ungradable pressure ulcers reported as developed whilst in our care. Following the completion of a pressure ulcer investigation tool we identified some areas where not all elements of the standards of care were delivered in a way that we would expect. However, it is difficult to confirm in all instances if this would have mitigated the pressure damage. In 17 out of the 26 identified cases the requirements of the DoC procedure were met. In the remaining 9 cases we were unable to determine to what extent the requirements of the act had been met due to the absence of documentation within the patient case notes. While we have observed steady progress in this area, we recognise the importance of continued improvement. Our focus remains on supporting staff to consistently evidence that the DoC process has occurred by providing feedback to Senior Charge Nurses to reinforce best practices in documentation and compliance.

When undertaking the Level 3 DoC reports all patients / next of kin were contacted, a full explanation and apology was provided.

Table 2 demonstrates the grading of the adverse events together with the reviews carried out:

Table 2:

Review carried out:	Extreme	Major	Moderate	Total
Duty of Candour Report	0	0	3	3
Patient Experience Letter	0	0	1	1
Management Review	0	1	0	1
Pressure Ulcer Investigation Tool	0	26	0	26
Fall Review Tool	0	3	0	3
Significant Adverse Event Review (SAER)	2	0	0	2
Total	**2**	**30**	**4**	**36**

Outstanding Significant Adverse Event Reviews from 2023/2024 DoC Annual Report

As of the finalisation of the DoC Annual Report 2023/24, seven Significant Adverse Events remained under investigation and had not yet been concluded. One of these is still awaiting completion. Of the six events with completed reviews:

- Three were graded with an outcome grading of 3: Minor System of Care Issues, indicating that the reviews identified minor or sub-optimal care or service provision, where an alternative approach may have led to a different outcome.
- Three were graded with an outcome grading of 2: Indirect System of Care Issues, where the reviews identified incidental or indirect sub-optimal care or service issues, along with opportunities for learning and improvement.

NHS Borders policies and procedures

In January 2025, InPhase, the newly procured Integrated Risk Management and Adverse Event Reporting System replaced Datix. The Patient Safety Team have reviewed the DoC function to ensure there was a fluid transition.

All adverse events within NHS Borders are reported through InPhase, adverse event reporting system. There are a series of process measures in place to ensure adverse event records have an accurate final decision regarding DoC. Each adverse event is reviewed to understand what happened, ensuring that the adverse event is appropriately graded and if required the appropriate review is undertaken. The level of review depends on the severity of the event. Through our adverse event management process, NHS Borders can identify adverse events that trigger the DoC procedure. From the recommendations of the review an improvement plan is developed, and actions are taken forward by the relevant management teams within their governance groups, ensuring actions are taken forward and lessons are learnt.

Staff support is offered throughout the review process through our line management structure as well as our Wellbeing Service. The Traumatic Events Staff Support Pathway is also available to support staff through our Psychological Services. NHS Borders acknowledges that staff can be exposed to difficult or traumatic situations as part of their work and are committed to supporting staff wellbeing across the organisation.

The Adverse Event Management Policy is currently under revision to ensure full alignment with two key national documents, the revised National Framework for Reviewing and Learning from Adverse Events in NHS Scotland (February 2025) and the Organisational Duty of Candour: Non-Statutory Guidance (March 2025).

In parallel, the Significant Adverse Event Guidance, which includes detailed guidance on the DoC together with our local DoC training materials will also be revised. This guidance supports Lead Reviewers by outlining structured processes for involving patients, families, and representatives, and for applying DoC principles effectively. These revisions aim to ensure consistency with national expectations and reinforce a transparent, compassionate, and person-centred approach to learning from adverse events.

The Patient Safety and Patient Experience Team undertook a review of the existing Complaints Handling and SAER processes to ensure robust mechanisms are in place for identifying instances where harm may have occurred. As part of this review, steps were taken to strengthen the process for recognising when the statutory DoC should be enacted.

Relevant members of the Patient Safety Team have participated in Compassionate Communication Skills Training, facilitated by NHS Education for Scotland (NES). This training was designed to enhance their communication competencies when supporting both patient/family meetings and staff debriefs throughout the Significant Adverse Event Review (SAER) process.

Additionally, team members attended the Adverse Event Networking Meeting, the Principal Educator (NES) led a session focused on compassionate facilitation. As part of this session an in-house facilitator pack tailored for Health and Social Care organisations in Scotland was provided to further support the development of reflective, person-centred practices in adverse event management. At a further date the Principal Educator (NES) also emailed new learning resources to support the DoC and adverse event management.

The Patient Safety Team facilitates Significant Adverse Event Lead Reviewer training covering the DoC, this is delivered through group sessions as well as offering 1:1 training if required. The NES DoC eLearning module link is also promoted within the training. As part of the newly qualified medical and nursing staff induction and First Line Manager training the Patient Safety Team facilitates DoC training.

Several other processes have been embedded to ensure that NHS Borders deliver what is required in relation to the DoC. All staff have the opportunity to receive training on adverse event management and implementation of the DoC so that they understand when it applies and how to trigger the duty. Facilitation tools and guidance are available to all staff via the organisational intranet.

Learning for the future

Attendance at the Adverse Event Network meetings provides valuable opportunities for ongoing professional development. Through participation, the Clinical Risk Coordinator and the Lead Nurse

for Patient Safety and Care Assurance are kept up to date with the latest training, guidance, and best practices relating to the DoC. These sessions support continuous learning and help ensure that local processes remain aligned with national expectations and evolving standards.

The Patient Safety Team will liaise with the Tissue Viability Steering Group to explore amending the Pressure Ulcer Investigation Tool. The proposed change aims to align the tool with other review templates by incorporating the Review Outcome Grading system, rather than the current binary classification of Avoidable or Unavoidable. This alignment will support consistency in reporting.

Patients and families are fully involved in our SAER process and are often consulted on how they would like the outcome of their case to be shared. We are very conscious of the small nature of the Scottish Borders and that even with significant reaction cases can be identifiable. We have raised this in national learning forums to assess what solutions others have found to this to ensure we can deliver our duties around patient confidentiality and data protection alongside sharing learning more publicly.

In that respect NHS Borders are currently testing a new approach to single side learning summaries that with permission from patients and /or families could be shared more widely. With permission from patients and/or families on a case-by-case basis we intend to then share learning summaries more widely in addition to the range of other reporting and sharing we do internally within NHS Borders and through the National Adverse Event Network and Scottish Patient Safety and Excellence in Care Programmes.

Appendix No.2
Review Outcomes:

Please indicate an outcome code for adverse event review indicating the findings of the review in relation to the link between care and outcome which will allow identification of those events where improvements are required. The following codes can be used:

1. **Appropriate care -** The adverse event review concluded that the healthcare and/or service was well planned and appropriately delivered. No care or service delivery problems were identified, and the adverse event outcome was unavoidable. However, it is likely there are still learning points for example highlighting areas of good practice.

2. **Indirect system of care issues -** The adverse event review identified indirect or incidental sub-optimal care or service issues. Lessons could be learned and any good practice points identified. For example, a protocol was not strictly followed or there was a delay in accessing case notes. However, these are examples of areas of improvement that were unlikely to have affected the final outcome.

3. **Minor system of care issues -** The adverse event review identified minor or suboptimal care or service provision. A different plan or delivery of care/service may have resulted in a different outcome. Factors were identified such as incomplete records or a delay in transferring the patient or service user. However, there was uncertainty regarding their impact on the outcome. Learning points have been identified and improvement plans developed.

4. **Major system of care issues -** The adverse event review identified. that a different plan and/or delivery of care would have been expected to result in a more favourable outcome. Factors were identified which negatively influenced or contributed to the adverse event outcome. For example, how the case was managed had a significant impact on the level of harm. Learning points have been identified and improvement plans developed.

Review of Outcome	**Please select outcome code**
1. Appropriate Care	
2. Indirect System of Care Issues	
3. Minor System of Care Issues	
4. Major System of Care Issues	

A national framework for reviewing and learning from adverse events in NHS Scotland: February 2025 – Healthcare Improvement Scotland