NHS Borders

Meeting:	**Clinical Governance Committee**
Meeting date:	**16 September 2026**
Title:	**Duty of Candour Annual Overview Report**
Responsible Executive/Non-Executive:	**Laura Jones, Director of Quality Improvement**
Report Author:	**Joanne Forrest, Quality Improvement Facilitator Safety & Experience**

1 Executive Summary

The following key points are brought to the attention of the Committee:

- This paper provides the Clinical Governance Committee with an update on NHS Borders' position in relation to organisational Duty of Candour and forms the content of the NHS Borders Annual Duty of Candour Report for submission to the Scottish Government.

- During the reporting period from 01 April 2025 to 31 March 2026, 133 adverse events were identified through NHS Borders' adverse event management processes where organisational Duty of Candour was considered. Of these, 116 have completed reviews and been assigned a Review Outcome Grading by the end of the reporting period.

- Following review, 24 adverse events were confirmed as meeting the criteria for organisational Duty of Candour. A further 17 events remain under investigation and are awaiting outcome grading at year end. These events will be considered for inclusion in an addendum should they subsequently be confirmed as meeting the organisational Duty of Candour criteria.

- The Duty of Candour procedure was carried out in all instances relating to Significant Adverse Event Reviews and Management Reviews. Further work is required to ensure Duty of Candour activity is consistently evidenced within patient records, particularly in relation to pressure ulcer investigations.

- NHS Borders continues to strengthen its adverse event and Duty of Candour arrangements through policy alignment with the revised national framework and guidance, staff training, improved review processes, and a continued focus on sharing learning to support safer, more effective and person-centred care.

2 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive
- Legal requirement

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

3 Report summary

3.1 Situation

3.1.1 The purpose of this paper is to provide the Clinical Governance Committee with an update on NHS Borders' current position in relation to the organisational Duty of Candour and the work in progress to ensure the duty is reliably applied across all clinical areas. This paper contains the content for NHS Borders Annual Duty of Candour Report to be shared with the Scottish Government and made available on the NHS Borders public website.

3.2 Background

3.2.1 On 01 April 2018 the statutory Organisational Duty of Candour legislation came into force which was revised in March 2025. The purpose of this organisational DoC is to support the implementation of consistent responses across health and social care providers when there has been an unexpected event which has resulted in death or harm (as defined in the Act). The requirements of this legislation are that people involved in an event understand what has happened, receive an apology and that the organisation learns from the events.

3.3 Assessment

3.3.1 **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 approximately 3,500 staff and operates:

- One main acute hospital
- Four community hospitals
- Four mental health inpatient units
- A wide range of community-based services and independent contractors

3.3.2 The organisation's purpose is to improve the health and wellbeing of the population and to deliver healthcare services that meet the needs of the Borders community. Delivering safe, effective and person-centred care is central to NHS Borders' approach.

3.3.3 **How many incidents happened to which the duty of candour applies?**
During the reporting period 01 April 2025 to 31 March 2026, a total of 133 incidents met the Duty of Candour threshold. These were unintended or unexpected events that resulted in death or one of the specified harms defined within the Duty of Candour (Scotland) Act and therefore required the Duty of Candour procedure to be undertaken.

3.3.4 This included 132 adverse events graded as Extreme or Major, together with one adverse event graded as Moderate that was identified through the local review process as meeting the criteria for organisational Duty of Candour.

3.3.5 Of the 133 adverse events reported during the reporting period, 116 had completed reviews and were assigned a Review Outcome Grading. Of these, 24 were assessed as meeting the criteria for organisational Duty of Candour. In accordance with the Healthcare Improvement Scotland National Adverse Event Framework, these events were assigned a Review Outcome Grading of 3 (Minor System of Care Issues), 4 (Major System of Care Issues) or avoidable, reflecting the review team's conclusion that a different approach to the planning or delivery of care or services may have resulted in a different outcome for the person affected. The remaining 17 adverse events were still under investigation and awaiting outcome grading at the end of the reporting period.

3.3.6 The outcome gradings for the 133 reviewed events are summarised below:

3.3.7 **Review Outcome Grading:**

Review Outcome Grading criteria:	**No. of significant adverse events**
Appropriate Care (1)	12
Indirect System of Care Issues (2)	37
Minor System of Care Issues (3)	12
Major System of Care Issues (4)	2
Sub total	**63**
Pressure Damage Reviews	
Avoidable	10
Unavoidable	12
Sub total	**22**
Other Reviews	
Not applicable	31
Still under investigation awaiting outcome grading	17
Sub Total	**48**
Total	**133**

3.3.8 Of the 31 cases recorded as Not Applicable, the Review Outcome Grading Framework was not applied because it is not appropriate for all types of reviews. In particular, Drug Related Death Reviews and Child Death Reviews form part of national reporting systems and are subject to established multi-agency and national review processes. These reviews utilise alternative methodologies and therefore local review outcome grading, including assessments of avoidability, is not applied.

3.3.9 In addition, some incidents reported as Significant Adverse Events are identified, following initial review, as meeting agreed exemption criteria for progression to a full SAER. As a result, these cases were excluded from formal review outcome grading.

3.3.10 Safety Reviews relating to staff incidents are also excluded from Duty of Candour review outcome grading, as they are managed under separate statutory processes, including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), rather than the Duty of Candour framework.

3.3.11 The 10 cases categorised as avoidable and 12 cases categorised as unavoidable relate to incidents of skin damage. It is recognised that the previous approach to classifying these cases as avoidable or unavoidable does not fully align with the broader Review Outcome Grading framework. A revised Pressure Ulcer Investigation Tool has now been implemented, which aligns with the Review Outcome Grading methodology. This revised approach supports a more consistent and structured assessment of care, rather than categorisation based solely on avoidability.

3.3.12 A further 17 significant adverse events remained under investigation at the end of the reporting period and were therefore awaiting review outcome grading. As these reviews have not yet concluded, it is not possible to determine whether they meet the criteria for organisational Duty of Candour. However, in line with organisational policy and best practice, the Duty of Candour process was initiated for each of these events pending the outcome of the review.

3.3.13 **Organisational Duty of Candour - Review Outcome Grading 3, 4 and Avoidable**
During the reporting period, 24 significant adverse events were assessed as meeting the criteria for organisational Duty of Candour. On completion of the review process, these events were assigned a Review Outcome Grading of 3 (Minor System of Care Issues), 4 (Major System of Care Issues) or Avoidable. In each case, the review concluded that a different approach to the planning or delivery of care or services may have resulted in a different outcome for the person affected.

3.3.14 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.

3.3.15 Table 1 presents data on the 24 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:

3.3.16 Table 1:

Nature of unexpected or unintended incident where Duty of Candour applies	Number
The death of a person	2
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	17
Changes to the structure of the person's body	3
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.	1
The person required treatment by a registered health professional in order to prevent:	
The person dying	0
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	0

3.3.17 **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.

3.3.18 The Pressure Ulcer Investigation Tool was used to review 16 adverse events which were directly in relation to Pressure Damage graded 3, 4 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.

3.3.19 In 10 of the 16 identified cases, the requirements of the DoC procedure were met. In a further 5 cases, it was not possible to determine the extent to which the requirements of the Act had been met due to insufficient documentation within the patient records. One case deviated from the Duty of Candour process because the patient had died from causes unrelated to the pressure damage. Following discussion with senior management, it was considered inappropriate to initiate the Duty of Candour process in view of the bereavement. While compliance has improved, further work is required to ensure that the Duty of Candour process is consistently evidenced within patient records. Our ongoing focus is to support staff through feedback and learning, working with Senior Charge Nurses to reinforce best practice in documentation and compliance, and to ensure that Duty of Candour activities are clearly recorded and auditable.

3.3.20 For the adverse event graded as Moderate, an initial review was completed and a Duty of Candour report confirmed that the patient had been contacted, provided with a full explanation of the incident, and offered an apology in accordance with Duty of Candour requirements.

3.3.21 **Outstanding Significant Adverse Event Reviews from 2024/2025 DoC Annual Report**
As at the finalisation of the Duty of Candour Annual Report 2024/25, 19 Significant Adverse Events remained under investigation and had not yet reached a conclusion. Of these, nine cases were associated with Review Outcome Gradings 3 and 4.

3.3.22 Five cases were assigned an outcome grading of 3. In one of these cases, it was necessary to deviate from the Duty of Candour procedure. Following advice from the Learning Disabilities Team Leader, it was determined that initiating a Duty of Candour discussion with the patient's next of kin would not be in their best interests. The next of kin was known to Learning Disabilities services, and there were concerns that discussing the adverse event could cause significant distress and that they may experience difficulty understanding the information and its context. No alternative next of kin or appropriate representative had been identified. In light of these circumstances, a decision was made not to proceed with the Duty of Candour process in this case.

3.3.23 Four cases were assigned an outcome grading of 4, and the Duty of Candour process was followed in all cases.

3.3.24 **NHS Borders policies and procedures**
NHS Borders continues to use InPhase, its electronic adverse event reporting system. All adverse events are reported through the system and reviewed to ensure appropriate grading, investigation and decision-making in relation to Duty of Candour requirements. The level of review undertaken is proportionate to the severity of the event. Learning identified through reviews is translated into improvement actions, which are monitored through local governance structures to support organisational learning, improve patient safety and reduce the risk of recurrence.

3.3.25 NHS Borders has a well-established process for monitoring Significant Adverse Events (SAEs) and incidents that meet the criteria for Duty of Candour. This includes weekly SAE tracker reports, coordinated and maintained by the Patient Safety Team, which are shared with senior management to oversee progress, ensure compliance with legislative requirements, and verify the accuracy of recorded Duty of Candour decisions, including alignment with causation and outcome gradings.

3.3.26 The Scottish Government's Organisational Duty of Candour: Non-Statutory Guidance (March 2025) and Healthcare Improvement Scotland's A National Framework for Reviewing and Learning from Adverse Events in NHS Scotland (February 2025, 5th Edition) were published in revised editions. NHS Borders is currently reviewing and updating its local Adverse Event Management Policy and supporting guidance to ensure alignment with these national publications. This work includes updating guidance relating to the involvement of patients, families and representatives throughout the review process and ensuring that Duty of Candour principles are applied consistently and effectively across all services.

3.3.27 As part of the SAER process, the line manager of any staff member identified to participate in a review is contacted in advance to ensure appropriate support arrangements are in place. Staff are also provided with an information leaflet outlining the review process and the support mechanisms available to them throughout their involvement.

3.3.28 Patients, families and representatives are similarly provided with information leaflets to support their understanding of the review process, their opportunities for involvement, and the sources of support available to them. This approach reflects NHS Borders' commitment to conducting reviews in a compassionate, person-centred manner while supporting all those involved in the review process.

3.3.29 Improvement action plans arising from recommendations within final Significant Adverse Event Review reports are monitored through established governance processes until all actions have been completed. These arrangements provide assurance that learning is implemented, improvements are embedded across services, and opportunities to enhance patient safety and quality of care are maximised.

3.3.30 Learning Summaries are produced for all SAERs. Summaries relating to reviews with an outcome grading of 3 and 4 are presented to the relevant governance groups to facilitate the sharing of learning, support reflection on identified issues, and promote improvements in patient safety and quality of care.

3.3.31 Training

Relevant members of the Patient Safety Team and Patient Experience Team have attended national person-centred care events facilitated by NHS Education for Scotland (NES). In addition, Compassionate Leadership training is available within NHS Borders and is being undertaken by members of both teams. These learning opportunities support the development of knowledge, skills and behaviours that promote compassionate, person-centred engagement with patients, families and carers, including in the application of Duty of Candour principles.

3.3.32 The Patient Safety Team delivers Significant Adverse Event Lead Reviewer Training, which is provided through both group sessions and one-to-one support where required. The training is designed to equip reviewers with the knowledge and skills required to undertake effective and proportionate reviews and includes:

- The rationale for commissioning a review
- Levels of review and review methodology
- Duty of Candour requirements and application
- Review outcome grading
- Review processes and analysis techniques
- Involving patients, families and representatives
- Supporting staff involved in adverse events
- Human factors and systems thinking
- Safety culture
- Use of the Care System Analysis Tool (CSAT)
- Identifying, sharing and embedding learning

3.3.33 Participants are also signposted to the NES Duty of Candour eLearning module to support their ongoing development and understanding of Duty of Candour principles.

3.3.34 In addition, the Patient Safety Team provides Duty of Candour training as part of the induction programmes for newly qualified medical and nursing staff, as well as for those undertaking First Line Manager training. To support the consistent application of adverse event management and Duty of Candour principles, a programme of Adverse Event and Duty of Candour training is currently being developed for senior nursing leaders.

3.3.35 NHS Borders also offers staff the opportunity to participate in the Compassionate Leadership Programme and the Quality Improvement Academy. These programmes support the development of leadership, communication and improvement skills, fostering a culture of compassion, openness, learning and continuous improvement across services, and complementing the organisation's approach to Duty of Candour and person-centred care.

3.3.36 Several other processes have been embedded to ensure that NHS Borders deliver what is required in relation to the Duty of Candour. All staff have the opportunity to receive training on adverse event management and implementation of the Duty of Candour 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.

3.3.37 **Learning for the future**

Following a Significant Adverse Event Review family meeting, the findings of the review were shared with the patient's spouse. During these discussions, it was highlighted that the patient had always wished for their body to be donated for university studies. Unfortunately, this was not possible due to the requirement for a post-mortem examination. In recognition of the patient's wishes and to ensure that learning could still be gained from their experience, NHS Borders worked with the family to develop a patient story, 'Ron's Story'. This resource is now incorporated into staff training and development programmes across NHS Borders, providing frontline staff with an opportunity to understand the patient's journey, reflect on the shortcomings identified in their care, and support learning and improvement for the future.

3.3.38 In two cases, there was uncertainty regarding the appropriate review outcome grading following completion of the review process. To support robust and consistent decision-making, review meetings were convened involving the review team and Executive Directors to consider the findings and agree the most appropriate outcome grading. This approach ensured that decisions were proportionate, transparent and reflected both the needs of the affected families and the organisational learning identified. The discussions were invaluable in supporting consensus where the grading was not clear-cut, and this approach will be adopted for future cases where additional consideration is required.

3.3.39 As part of the NHS Borders Quality Enabling Strategy, NHS Borders will continue to strengthen learning and improvement by creating greater opportunities for staff, patients, families and carers to reflect on and learn from occasions when care has not gone as intended. This will include further embedding a human factors approach within Significant Adverse Event Reviews and other review processes to better understand the system and contextual factors that influence care delivery. We will continue to enhance learning from adverse event reviews, mortality and morbidity reviews, patient feedback and complaints by improving how learning is shared across the organisation and embedding thematic learning within education, training and quality improvement programmes. NHS Borders will also continue to support timely, honest and compassionate engagement with patients and families, in line with the Duty of Candour process, ensuring that their experiences inform service improvement and contribute to the delivery of safer, more effective and person-centred care.

3.4.1 Quality/ Patient Care

This report is aligned to the NHS Borders and national patient safety programme.

3.4.2 Workforce

Services and activities are provided within agreed resources and staffing parameters.

3.4.3 Financial

Services and activities are provided within agreed resources and staffing parameters.

3.4.4 Risk Assessment/Management

Systems, processes and procedures need to be strengthened to ensure NHS Borders will be able to fulfil their obligation to implement the requirements of the Duty of Candour as set out by the Scottish Government.

3.4.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed as this report is for awareness purposes and does not directly impact on people.

3.4.6 Climate Change

None noted.

3.4.7 Other impacts

None noted.

3.4.8 Communication, involvement, engagement and consultation

The content of the report has been considered by a range of stakeholders in NHS Borders and advice sought from regional and national colleagues. The annual report will be available through the NHS Borders public website for information.

3.4.9 Route to the Meeting

The content of this paper is reported to Clinical Boards, Clinical Governance Groups and to the Board Clinical Committee.

3.5 Recommendation

- Awareness
- Discussion

The Board/Committee will be asked to confirm the level of assurance it has received from this report:

- Systems and processes - significant assurance
- Outcome – moderate assurance – relating to improvements required specifically to the application of Duty of Candour in pressure damage

4 List of appendices

- Appendix No 1 – Review Outcome Grading Template

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

Organisational Duty of Candour: non-statutory guidance - revised March 2025 - gov.scot