Lothian NHS Board

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Date 26/06/2026
Your Ref
Our Ref 11468

Enquiries to Richard Mutch
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Dear

FREEDOM OF INFORMATION – DIAGNOSIS FAILURE

I write in response to your request for information in relation to diagnosis failure.

Question:

- *PART 1: Incident Reporting Data (Datix or equivalent)*
  Using your incident reporting system (e.g. Datix), please provide:
  1. Total incidents
  The number of incidents recorded under categories including:
  "delayed diagnosis"
  "missed diagnosis"
  "diagnostic error" (or equivalent categories used locally)

Answer:

The table below details the total number of adverse events (incidents) reported on DATIX under the Category **Diagnosis Failure** and Sub Category **Delay in diagnosis** and **Wrong Diagnosis** for period 01/01/2020:06/05/2026 (Data for FOI). The data is broken down by Sub Category and Calendar year.

	2020	2021	2022	2023	2024	2025	2026	Total
Delay in diagnosis	21	19	38	26	45	56	18	223
Wrong diagnosis	9	41	8	16	22	18	10	124
Total	30	60	46	42	67	74	28	347

Question:

2. Harm severity breakdown
A breakdown of these incidents by recorded harm level:
No harm
Low harm
Moderate harm
Severe harm
Death

Answer:

The table below details the total number of adverse events (incidents) reported on DATIX under the Category **Diagnosis Failure** and Sub Category **Delay in diagnosis** and **Wrong Diagnosis** for period 01/01/2020:06/05/2026 (Data for FOI). The data is broken down by Severity and Calendar year.

	2020	2021	2022	2023	2024	2025	2026	Total
No known adverse effect at this time	17	43	26	23	43	40	14	205
Harm to a person -minor	≤5	8	12	10	≤5	10	≤5	53
Harm to a person -moderate	≤5	≤5	≤5	≤5	6	10	≤5	39
Harm to a person -major	≤5	≤5	≤5	≤5	10	13	≤5	39
Harm to a person -death	≤5	≤5	≤5	0	≤5	≤5	≤5	10
Total	30	60	46	42	67	74	28	347

Question:

3. Time series
The above data broken down by calendar year.

Answer:

See Q1 and 2.

Question:

4. Service/specialty
Where held, a breakdown by clinical area or specialty (e.g. emergency department, oncology, primary care interface).

Answer:

The table below details the total number of adverse events (incidents) reported on DATIX under the Category **Diagnosis Failure** and Sub Category **Delay in diagnosis** and **Wrong Diagnosis** for period 01/01/2020:06/05/2026 (Data for FOI). The data is broken down by Management Team and Calendar year.

	2020	2021	2022	2023	2024	2025	2026	Total
Outpatient and Associated Services	≤5	0	0	0	≤5	0	0	≤5
Diagnostics, Anaesthetics, Theatres and Critical Care	9	42	22	8	25	20	7	133
East Lothian Acute and Ongoing Care/Day Services	≤5	0	0	0	≤5	0	0	≤5
RIE Hospital Site Management Team	8	7	11	7	8	22	6	69
Oral Health Service	≤5	0	0	≤5	≤5	0	0	≤5

STJ Hospital Site Management Team	7	≤5	6	≤5	11	7	≤5	43
Women's and Children's	≤5	≤5	≤5	8	7	8	6	34
WGH Hospital Site Management Team	≤5	≤5	≤5	6	≤5	≤5	≤5	21
Primary Care Directorate	0	≤5	0	0	0	0	0	≤5
Royal Edinburgh & Associated Services	0	≤5	0	0	≤5	≤5	0	≤5
East Lothian Community Nursing	0	0	≤5	0	0	0	0	≤5
East Lothian Primary Care	0	0	≤5	0	0	0	0	≤5
Sexual Health	0	0	≤5	≤5	≤5	≤5	0	10
East Lothian Mental Health & Substance Misuse	0	0	0	≤5	0	≤5	0	≤5
Edinburgh Mental Health, Learning Disability and Substance Use	0	0	0	≤5	≤5	0	≤5	≤5
Public Health	0	0	0	≤5	≤5	0	0	≤5
E-Health	0	0	0	0	≤5	0	0	≤5
Edinburgh Primary Care	0	0	0	0	≤5	≤5	0	≤5
Pharmacy	0	0	0	0	≤5	0	0	≤5
West Lothian AHPs	0	0	0	0	≤5	≤5	0	≤5
Edinburgh Hospitals, Care Homes and Tech	0	0	0	0	0	≤5	0	≤5
East Lothian AHPs	0	0	0	0	0	≤5	≤5	≤5
HMP Healthcare Services	0	0	0	0	0	≤5	≤5	≤5
WL Mental Health	0	0	0	0	0	0	≤5	≤5
Total	30	60	46	42	67	74	28	347

Question:

PART 2: Significant Adverse Events (SAEs)
Please provide:
5. SAE volume
The number of Significant Adverse Event (or equivalent) reviews where: delayed, missed or incorrect diagnosis was identified as a contributing factor

Answer:

The table below details the total number of Major Harm and Death adverse events (incidents) reported on DATIX under the Category **Diagnosis Failure** and Sub Category **Delay in diagnosis** and **Wrong Diagnosis** for period 01/01/2020:06/05/2026 (Data for FOI). The data is broken down by Sub Category and Calendar year.

We do not have an exact field for “contributing factor”, however data has been provided based on the category and sub-category of adverse event that the incident was reported under.

	2020	2021	2022	2023	2024	2025	2026	Total
Delay in diagnosis	≤5	≤5	≤5	≤5	11	12	≤5	41
Wrong diagnosis	≤5	≤5	0	0	≤5	≤5	≤5	8
Total	≤5	≤5	≤5	≤5	13	14	≤5	49

The data is broken down by Sub Category and Severity.

	Harm to a person - major	Harm to a person - death	Total
Delay in diagnosis	32	9	41
Wrong diagnosis	7	≤5	8
Total	39	10	49

Question:

6. Outcome breakdown
Of these, how many involved: Severe harm Patient death

Answer:

The table below details the total number of Major Harm and Death adverse events (incidents) reported on DATIX under the Category **Diagnosis Failure** and Sub Category **Delay in diagnosis** and **Wrong Diagnosis** for period 01/01/2020:06/05/2026 (Data for FOI). The data is broken down by Review Outcome and Severity.

39 adverse events have been reviewed and closed with an outcome code selected, the other 10 are still being reviewed which is why the figures differ between Q5 and Q6.

	Harm to a person - major	Harm to a person - death	Total
Outcome 1	7	≤5	10
Outcome 2	14	≤5	16
Outcome 3	≤5	≤5	9
Outcome 4	≤5	0	4
Total	30	9	39

Outcome Codes

1	**Appropriate care** - The adverse event review concluded that the care and/or service was well planned and appropriately delivered; no care or service delivery problems were identified; and the adverse event outcome was ultimately unavoidable. However, it is likely there are still learning points (especially good practice points).

2	**Indirect system of care issues** - The adverse event review identified indirect or incidental sub-optimal care or service issues and lessons that could be learned (and good practice points). However, these were unlikely to have affected the final outcome. For example, a protocol was not strictly followed or there was a delay in accessing the case notes, but these were unlikely to have affected the final outcome.
3	**Minor system of care issues** - The adverse event review identified minor or sub-optimal care or service provision and that a different plan or delivery of care/service may have resulted in a different outcome. For example, system or management factors were identified (such as incomplete records or a delay in transferring the patient or service user), but there was uncertainty regarding their impact on the final 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 or service would, on the balance of probability, 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.

To protect the identity of the individuals involved any figure of 5 or less has not been shown in this response. Since we do not have their consent to release this data from their records, the information is exempt under section 38(1)(b) of the Freedom of Information (Scotland) Act i.e. to provide it would breach the Data Protection Act (2018).

I hope the information provided helps with your request.

If you are unhappy with our response to your request, \you do have the right to request us to review it. Your request should be made within 40 working days of receipt of this letter, and we will reply within 20 working days of receipt. If our decision is unchanged following a review and you remain dissatisfied with this, you then have the right to make a formal complaint to the Scottish Information Commissioner within 6 months of receipt of our review response. You can do this by using the Scottish Information Commissioner's Office online appeals service at www.itspublicknowledge.info/Appeal. If you remain dissatisfied with the Commissioner's response you then have the option to appeal to the Court of Session on a point of law.

If you require a review of our decision to be carried out, please write to the FOI Reviewer at the email address at the head of this letter. The review will be undertaken by a Reviewer who was not involved in the original decision-making process.

FOI responses (subject to redaction of personal information) may appear on NHS Lothian's Freedom of Information website at: https://org.nhslothian.scot/FOI/Pages/default.aspx

Yours sincerely

ALISON MACDONALD
Executive Director, Nursing
Cc: Chief Executive