**NAME OF MEETING:** CARE AND CLINICAL GOVERNANCE
**DATE OF MEETING:** 6th December 2018

**Agenda item** Significant Adverse Events Report
**For Assurance**

**Executive Sponsor:** Mr Andrew Murray, Medical Director

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**Executive Summary**
This report provides the Clinical Governance Working Group with information on significant adverse events (SAEs) and the actions being taken to continually improve the quality of clinical care and reduce harm to patients.

**Recommendation:**
The members of the Care and Clinical Governance are asked to note and comment on the key issues highlighted below.

**Key Issues to be considered:**
- The update on the review of current SAE reviews
- Note the update of the actions in response to the implementation of the recommendations of the NHS HIS national framework
- Note the current self assessment of adverse events baseline exercise

**Financial Implications**
None

**Workforce Implications**
N/A

**Risk Assessment**
N/A

**Relevance to Strategic Priorities**
Part of Clinical Governance and Risk Management arrangements.

**Equality Declaration**
N/A

**Consultation Process**
N/A

**1. Significant adverse events**

**Current significant adverse event reviews.**

The significant adverse event (SAE) reviews that are currently in progress are summarised in table 1**.** SAE reviews that have exceeded the timescale from decision to proceed to completion of the report (90 working days) are highlighted on the table. SAE reviews that have been completed but where progress with recommendations and actions has yet to be reported to the Clinical Governance Working Group are shaded. Information on reasons for delays has been added to the comments section of the report.

**TABLE 2: Community Services Directorate**

| Time to Commission Target 10 working days after the event | Date Review commissioned | SAER number | Event | Report due 90 working days from date SAE commissioned | Status | Immediate actions taken | Comments |
|---|---|---|---|---|---|---|---|
| 41 Working Days | 19/10/18 | 00042 | IP death | Report due – 28/02/19<br>30 working days @ 30/11/18 | In Progress | Immediate action taken to reduce future risk of recurrence. | Family meeting 16/11/18 |

## 2. Update on Local Implementation of the NHS Healthcare Improvement Scotland learning from Adverse Events through reporting and review: A National Framework for Scotland

The following areas of work describe continuing actions that relate to the operationalisation of the national framework. The national framework has been updated since these recommendations were published. The updated guidance has been reviewed in the context of updating the Adverse Event and Significant Adverse Event Policy.

| Recommendation | Update | Lead | Timescale |
|---|---|---|---|
| HIS Recommendation 18.3<br>Consistently provide meaningful feedback to staff to encourage a reporting attitude | The development of additional mechanisms to share learning will be ongoing | MI<br>GM's<br>AMD's<br>HON | Ongoing |
| HIS Recommendation 21.7<br>Continue to demonstrate that the system allows thematic learning to take place | Key areas of learning have been used to develop a series of 'safety cards' which will be tested by front line clinical teams. Topics include:<br>• Falls and falls with harm<br>• Prevention of pressure injury<br>• Medicines safety<br>• The recognition of delirium<br>Themes and trend from adverse events are also an agenda item at the risk network group meeting for feedback to directorates via members of the group. | | Dec 2018-Mar 2019 |
| HIS Recommendation 19.4<br>Demonstrate a systematic approach to staff training | Education Plan to support implementation of revised policy once this has been approved by the Clinical Governance Committee | MI NW<br>Clinical Directorates | Jan-March 2019 |
| HIS Recommendation 22.8<br>Assess if grading processes ensure consistency of response and appropriate management of incident reporting. | Regular meetings are held with directorate teams to review adverse events, this included review of grading. | MI<br>NW | Ongoing |

**3. Reporting baseline for adverse events**

The Health and Sport Committee published a report on the Governance of the NHS in Scotland – ensuring the delivery of the best healthcare for Scotland in July 2018. The report contained commentary and recommendations regarding the mangment of adverse events by NHS Boards and the role of Healthcare Improvement Scotland and its assurance function. Responses to this report by the cabinet secretary include actions for Healthcare Improvement Scotland. These comprise the development of a reporting baseline to establish the status of adverse event management processes in NHS boards as set out in the *Learning from adverse events through reporting and review: A national framework for Scotland*, revised in July 2018.

NHS HIS are utilising an adapted version of the Quality of Care Approach self-evaluation tool to request information specific to the management of adverse events from NHS Boards. If required, they may follow this with teleconferences with NHS boards to ensure they fully understand their responses to the questions posed.

This information will be collated and reported by NHS HIS to inform a number of purposes:

- to inform Scottish Government in response to the Health and Sport Committee Report
- to inform the revision of the national framework
- to further develop the adverse events external assurance component of the Quality of Care approach,
- to identify focused improvement support either bespoke or aligned to an existing ihub portfolio, and
- to identify areas of good practice and areas of challenge

Completed questionnaire have been requested by **28th November 2018**

**Monica Inglis**
**Head of Clinical Governance**
**November 2018**