

Agenda Item 7

**Referral from the Clinical
Governance Committee – Adverse
Events Management: NHS Board
Self-Evaluation Report**



Title: Referral from the Clinical Governance Committee –
Adverse Events Management: NHS Board self-
evaluation Report

Meeting: Clinical and Care Governance Committee

Date: 7 November 2019

Submitted By: Medical Director

Action: For Noting

1. Introduction

- 1.1. This report refers the Adverse Events Management: NHS Board self-evaluation Report considered by the Clinical Governance Committee of the Health Board on 11 October 2019. The Committee agreed to refer the report at that meeting.

2. Recommendations

- 2.1. It is recommended that the Committee note the report.

Resource Implications

There are no resource implications arising from the report recommendations.

Impact on IJB Outcomes and Priorities

There is no impact resulting from the report recommendations.

Legal & Risk Implications

There are no legal or risk implications arising from the report recommendations.

Consultation

No consultation was required on the report recommendations.

Equalities Assessment

There are no equalities impacts arising from the report recommendations.

Submitted by: Medical Director, NHS Forth Valley

Author – Jack Frawley, Committee Services Officer

Date: 30 October 2019

Appendix 1 – Adverse Events Management: NHS Board self-evaluation Report

List of Background Papers: No background papers were relied on in the preparation of this report.



Adverse Events Management: NHS Board self-evaluation Report

September 2019

This report is embargoed until 14:30 on
Tuesday 10 September 2019

Healthcare Improvement Scotland is committed to equality. We have assessed the review function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Advisor on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net

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First published September 2019

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Introduction

About this report

1. In July 2018, the Health and Sport Committee published a report on [The Governance of the NHS in Scotland - Ensuring Delivery of the Best Healthcare for Scotland](#). The report contains commentary and recommendations relating to the management of adverse events by NHS boards and the role of Healthcare Improvement Scotland (HIS) and its assurance function. The Cabinet Secretary for Health and Sport's [responses to the report](#) include the following actions for HIS:
 - develop a reporting baseline to establish the status, gaps and inconsistencies in adverse event management processes in NHS boards, and
 - further develop a methodology to deliver an external assurance component to adverse event management across NHSScotland in line with HIS's quality of care approach and The Duty of Candour Procedure (Scotland) Regulations 2018 reporting requirements.
2. This report provides the key messages and detailed findings of the reporting baseline and will inform our future methodology for undertaking external assurance and appropriate focus for improvement.

Background

3. In 2012, the Cabinet Secretary for Health, Wellbeing and Cities Strategy instructed HIS to carry out a review of the clinical governance systems and processes in NHS Ayrshire & Arran, in particular those that relate to their management of critical incidents, adverse events, action planning and local learning. This followed a decision by the Scottish Information Commissioner on 21 February 2012 on NHS Ayrshire & Arran's response to a Freedom of Information (Scotland) Act appeal about critical incident reviews and significant adverse event reviews.
4. A key recommendation of that work was the need to develop a consistent and agreed Scotland-wide approach to the identification, investigation, reporting and learning from significant adverse events. This led to the Cabinet Secretary for Health, Wellbeing and Cities Strategy instructing HIS to develop a national framework for the management of adverse events and a programme of reviews. Between autumn 2012 and spring 2014, we visited every patient-facing NHS board to review their processes for managing adverse events and published the findings on our website:
www.healthcareimprovementscotland.org/our_work/governance_and_assurance/learning_from_adverse_events/adverse_events_review_reports.aspx

5. In September 2013, we developed and published the first edition of the national framework for managing adverse events following extensive consultation and engagement across Scotland. The framework supports NHS boards to standardise processes for managing and learning from adverse events. A revised second edition was published in April 2015 following the development of a number of tools to support implementation of the framework. These can be found on the [Adverse Events Community of Practice](#) website.
6. The national framework seeks to ensure that no matter where an adverse event occurs in Scotland:
 - the affected person receives the same high quality response
 - organisations are open, honest and supportive to the affected person, apologising for any harm that occurred
 - any staff involved are supported in a consistent manner
 - events are reviewed in a consistent way, and
 - learning is shared and implemented across the organisation and more widely to improve quality of services.
7. The framework includes a national definition of an adverse event, guidance on reporting, accountability, responsibilities and learning, and principles for an open, just and positive safety culture. It provides definitions, tools and supporting documentation based on the six stages to managing an adverse event (Appendix 1). The six stages are described as:
 - Risk assessment and prevention
 - Identification and immediate actions following an adverse event
 - Initial reporting and notification
 - Assessment and categorisation
 - Review and analysis
 - Improvement planning and monitoring.
8. The framework states that organisations should develop their own local policies and procedures to support the implementation of this nationally-defined process.

9. We carried out a follow-up review of the progress all NHS boards had made with implementing the framework. The report, published in May 2016, highlighted areas of good practice, including patient, family and staff engagement, local development of tools and supporting guidance, and sharing of learning locally. Ongoing challenges were highlighted in respect of capacity, governance and consistency/standardisation of adverse event management. The full report is available here:
www.healthcareimprovementscotland.org/our_work/governance_and_assurance/learning_from_adverse_events/learning_report_2016.aspx
10. In March 2017, the National Clinical Director, the Chief Medical Officer and Chief Nursing Officer wrote a joint letter to all NHS boards. This letter clarified expectations around the NHS boards' assurance processes to make sure that they can demonstrate that they follow the national framework.
11. The third edition of the [Learning from Adverse Events through Reporting and Review: A National Framework for Scotland](#) was published in July 2018 and incorporates the [Duty of Candour Procedure \(Scotland\) Regulations 2018](#) which came into force on 1 April 2018. The duty of candour is a legal requirement for organisations to inform and involve people (and their families) when they have been harmed as a result of the care or treatment they have received.

Methodology

12. In order to establish a reporting baseline across Scotland, we tailored our quality of care approach self-evaluation tool. The quality of care approach aims to bring consistency to HIS' external quality assurance work and to support service providers to evaluate their own care delivery. The approach includes the [Quality Framework – Evaluating and Improving Healthcare](#), to guide people through this evaluation. The quality framework domains and quality indicators are outlined in Appendix 2 of this report.
13. We used the relevant domains within the quality framework (domains 1, 2, 3, 5, 6 and 9) and developed the questions in each domain based on the guidance in the national framework to create the self-evaluation tool (Appendix 3).
14. We asked all 19 patient-facing NHS boards to use the tool to self-evaluate their systems and processes for the management of adverse events that involved patients (see Appendix 4 for a list of all patient-facing NHS boards). The information requested in each section of the tool focused on various elements of the six stages of adverse event management.
15. Organisations were also asked to submit copies of their local policies and procedures for risk management and the management of adverse events so that we could consider if these align to the framework.

16. The HIS adverse event team has analysed the information submitted in the self-evaluation tool and the local policies and procedures, and the findings of this initial paper-based exercise are presented in the following sections of this report. A subsequent round of teleconferences was arranged with all 19 NHS boards to further investigate any apparent gaps or inconsistencies in the implementation of the stages of adverse event management process outlined in the national framework. Whilst the information was requested in line with our quality of care approach, we have mapped the responses back to the six stages of the adverse event management process and the findings from this exercise are presented against these stages.

Key messages from the self-evaluation

Reported areas of strength

17. Overall, feedback on the national framework was very positive, with NHS boards describing it as a useful and comprehensive source of guidance.
18. All NHS boards' policies describe an adverse event in line with the definition in the national framework.
19. All NHS boards reported that they engage patients, families and carers in adverse event processes and they provide support for staff following an adverse event.
20. Out of 19 NHS boards, 18 reported numbers of adverse events (all categories) which were statistically consistent with the national average. One NHS board reported a higher than average number of adverse events.
21. All NHS boards reported they use the recommended risk matrices to assess adverse events, and 18 out of 19 describe categorising these in line with the national framework.
22. Out of 19 NHS boards, 18 reported numbers of Category I adverse events that were statistically consistent with the national average. One NHS board reported a higher than average number of Category I events.
23. Out of 19 NHS boards, 18 described three levels of review for adverse events and all NHS boards reported they are using validated tools and techniques as part of the review process.
24. All NHS boards, except one, reported they offer the family a copy of the review report along with the opportunity to meet to discuss the findings (should they wish).
25. All NHS boards reported they have operational, management and governance structures and groups in place to oversee the development and implementation of improvement plans and to identify themes from learning.
26. All NHS boards reported they have systems and tools in place to support sharing learning locally – 12 out of 19 NHS boards are using the HIS learning summary template.
27. NHS boards use a variety of methods, based on the list of example local measures within Appendix 3 of the national framework, to monitor their local adverse event process.

Reported areas for improvement

28. Out of 19 NHS boards, 18 described systems and structures in place to ensure an appropriate level of review is applied. However, there is variation in the number of Category I events that receive a Level 1 review. There is variation in the processes applied which determine how NHS boards assess and decide the level of review to be undertaken.
29. There is variation in how review reports and findings are shared with staff.
30. There is not a consistent approach for seeking feedback from patients, families, carers and staff about their experiences of the adverse events management process. Whilst this is not an explicit requirement within the national framework, evaluation is acknowledged as good practice in understanding the effectiveness of the system or process.
31. There is variation in the processes to assure staff that improvements are being implemented.
32. There is variation in the use of the HIS Community of Practice (CoP) website and in the perceived benefits of using this as a forum to share learning nationally.
33. Evaluating the impact of changes on patient outcomes and demonstrating sustained improvements as a result of improvement plans is a challenge in many NHS boards.
34. A consistent approach to the management of adverse events across all aspects of health and social care settings is still at an early stage and engagement with primary, secondary and social care is variable.

Next steps

35. Appendix 5 and Appendix 6 of this report provide an overview of where there are gaps, variation and inconsistencies in the application of the national framework. These require to be considered in the context of the Health and Sport Committee's report, and Cabinet Secretary for Health and Sport's responses, referred to in section 1 above. Building on the baseline exercise, and taking into account a number of related workstreams within both HIS and Scottish Government, we propose the following actions:

- HIS will explore with stakeholders whether standardising the events that would trigger a Level 1 review (as is being currently tested within the maternity and neonatal adverse event framework) would help to ensure a consistent approach to decision making around these events, taking account of concerns expressed by the Health and Sport Committee. A scoping exercise to ascertain the main themes of harm recorded as Category I is underway. This will inform a proposal for the reporting and monitoring of local decision making in respect of specific harms.
- HIS will work with Scottish Government to establish whether there is the potential to develop a national system for reporting specific Category I events, and the review applied, for further monitoring and assurance.
- HIS will engage with key stakeholders to consider how best to support sharing and implementing learning at a national level from adverse events and from other sources such as Fatal Accident Inquiries.
- HIS will identify internal clinical leadership for the adverse events programme of work.
- HIS will consider options for future assurance work, through the quality of care approach, potentially in relation to the effectiveness of NHS boards' engagement with patients, families and carers, and the effectiveness of governance structures, in line with the national framework.
- HIS and Scottish Government will develop a joint action plan to progress a number of workstreams related to adverse events and the findings of the baseline review, including the Maternity Adverse Event Framework, Being Open, Duty of Candour, suicide reviews, The Scottish Mortality and Morbidity Programme (SMMP), Death Certification Review Service and the National Hub for Reviewing and Learning from Child Deaths.
- Scottish Government will work with HIS to clearly articulate potential new commissions in relation to the above, in line with the HIS Operating Framework.
- Further stakeholder engagement and bringing together related workstreams should allow the appropriate areas of national focus to be confirmed.

Detailed findings from the self-evaluation

- 36. The national framework provides guidance on how an adverse event should be managed and outlines the six stages of adverse event management (Appendix 1). The framework acknowledges that the circumstances surrounding each adverse event will vary and the response should be proportionate to its scale, scope, complexity and opportunity for learning.
- 37. The national framework defines an adverse event as “...an event that could have caused (a near miss), or did result in harm, to people or groups of people.”

All NHS boards’ policies describe an adverse event in line with the definition in the framework.

Stage 1: Risk assessment and prevention

- 38. Stage 1 states that organisations should strive to embed a positive safety culture and create an environment that is open, just and informed. Organisational culture is based on the values of trust, openness, and equality and diversity, which encourages and supports staff to recognise, report and learn from adverse events. The national framework provides guidance on key elements of a safety culture that should be promoted and supported.
- 39. All NHS board policies include statements and information in relation to creating and supporting a safe, fair, open and just culture.
- 40. We wanted to understand how NHS board leadership promotes an open and just culture to reporting and learning from adverse events. We identified, through the self-evaluation responses, that all NHS boards use similar methods to encourage staff to report adverse events. For example, regular risk management training, adverse event identification, and reporting and review training is available at various levels for all staff. The ability to report adverse events on Datix (or similar electronic reporting systems) is also open to all staff, which allows for timely identification and reporting of issues. Organisations provide dedicated intranet pages which contain policies, procedures, toolkits and guidance on adverse events and duty of candour. Additional measures have been implemented in some organisations such as the introduction of safe spaces for staff to raise concerns and executive safety walk rounds where staff are encouraged to raise concerns in person.

41. The national framework also outlines the responsibilities of organisations in relation to the duty of candour legislation: to be open, honest and supportive towards anyone affected by an unexpected or unintended event which resulted in harm or death.
42. Section 23(1) of The Duty of Candour Procedure (Scotland) Regulations 2018 states that “an ‘apology’ means a statement of sorrow or regret in respect of the unintended or unexpected incident.” The Act sets out that ‘an apology’ or other step taken in accordance with the duty of candour procedure does not of itself amount to an admission of negligence or a breach of a statutory duty. One NHS board reported that, whilst they meet the requirements of the Duty of Candour regulations, creating a supportive and reflective culture for senior clinicians to discuss and reflect upon adverse events is difficult when litigation and or “blame” is a concern.
43. The self-evaluation tool asked organisations to consider their responses in relation to adverse events, including those which triggered duty of candour. We have not reported separately on duty of candour events in this report. NHS boards must provide Scottish Government with an annual report which outlines the way that the duty of candour procedure has been followed for all the cases that they have identified. The first year of duty of candour reporting is scheduled for April 2019.

All NHS boards have described the mechanisms they have in place to embed a positive safety culture, in which reporting and learning from error is the norm.

Stage 2: Identification and immediate actions following an adverse event

44. Stage 2 states that, in all instances, the first priority is to ensure the needs of the individuals affected by the adverse event are attended to, including any urgent clinical care which may reduce the harmful impact, namely a safe environment should be re-established.
45. The national framework goes on to describe the importance of ensuring that the person(s) (and their family) must be cared for, with compassion and understanding, even if simply making regular contact to keep people informed and involved. Organisations should also give early consideration to the provision of information and support to all people involved.

46. All NHS board policies describe the immediate actions required following an adverse event, including establishing a safe environment, attending to the immediate needs of those affected and taking actions to prevent immediate reoccurrence.
47. All NHS board policies describe how patients, families and carers should be supported and involved in the process. The self-evaluation responses provided information on how NHS boards deliver on this commitment. All NHS boards described ways in which patients, families and carers are informed of, and invited to contribute to, the review process including providing the opportunities for them to ask questions they would like the review to consider and offering support throughout the process. Specifically the responses noted:
- implementation of 'Being Open' principles (17 NHS boards)
 - providing a named point of contact for patients and families (11 NHS boards)
 - providing patient and family information leaflets (12 NHS boards), and
 - identifying the patient/family's preferred method of communication, for example face to face, email or telephone (13 NHS boards).
 - routinely sharing a copy of the report with the patient or family (18 NHS boards)
48. The national framework states that staff involved in an adverse event should also be supported. The framework also provides guidance for NHS boards on supporting tools which should be included in local NHS boards' processes.
49. Responses to the self-evaluation tool identified that a number of support mechanisms for staff were available across NHS boards. These included:
- intranet pages with links to information about the support available to staff, including processes for managers to follow to ensure staff feel supported
 - using the suite of national support leaflets for staff
 - immediate debriefs with line managers
 - referral to staff support services, occupational health and employee counselling
 - dedicated training sessions to support staff interviews, and
 - implementation of values based reflective practice.

All NHS boards reported that they engage patients, families and carers in adverse event processes.

All NHS boards reported that they provide support for staff following an adverse event using a range of tools and methods.

However, there is variation in how engagement with patients and staff is carried out in practice, which will require further discussion with NHS boards.

Stage 3: Initial reporting and notification

50. Stage 3 states that when an adverse event occurs, the organisation's electronic adverse event reporting system must be used.
51. We asked NHS boards to provide information on the electronic reporting system they use. All but three NHS boards use the Datix reporting system to report and record adverse events. The other systems used are Respond, Q-Pulse and Safeguard.
52. The national framework states that an organisation-wide approach should be in place for training staff in adverse event reporting.
53. From the self-evaluation responses, all NHS boards provide regular training and education for staff. This training is provided for reporters, reviewers and approvers of adverse events which suggests a whole systems approach. Out of 19 NHS boards, 17 have annual training plans in place and provide mandatory reporting training as part of an induction programme. Two NHS boards reported that whilst there are no formalised annual training plans, staff are educated on adverse events management through shadowing and mentoring. NHS boards that have formal training plans in place routinely use the following methods to educate staff:
 - eLearning modules
 - formal classroom style training
 - open discussion forums
 - peer support, and
 - guidance materials and toolkits.
54. The national framework states that specific events must be reported to external organisations, where required. With the exception of one special board, all NHS board policies make reference to external reporting when required.
55. We asked NHS boards for the number of adverse events reported from 1 October 2017–1 October 2018. Appendix 6 provides an overview of the number of reported adverse events across NHS boards. The key messages are:
 - an average of 17 adverse events (all categories) per 1,000 population were reported for acute services in NHSScotland, and

- 18 out of 19 NHS boards reported numbers of adverse events (all categories) which were statistically consistent with the Scotland average. One NHS board reported a higher than average number of adverse events.

Training and education for reporting and managing adverse events is provided on a regular and ongoing basis by all NHS boards across Scotland.

The total number of adverse events reported across NHSScotland is statistically consistent with the Scotland average for 18 out of 19 NHS boards. One NHS board has a higher reporting rate.

Stage 4: Assessment and categorisation

56. The national framework provides guidance on the categorisation of adverse events (based on the level of harm) and also the level of review that should be applied (the suggested action as a result of an event).
57. The descriptions of Category I, II and III detailed within the national framework and summarised below are based on the impact of harm. The framework also acknowledges, with some exceptions, that the category of the event will support the decision-making process for the level of review required. The framework describes three categories that should be used:
 - Category I – events that may have contributed to or resulted in permanent harm
 - Category II – events that may have contributed to or resulted in temporary harm
 - Category III – events that had the potential to cause harm but no harm occurred.
58. Category I events which have the most severe impact of harm are often described as significant adverse events. This categorisation requires some initial assessment of the event, which can be aided by a decision tool such as the NHSScotland risk matrices or the National Coordinating Council for Medical Error Reporting and Prevention (NCC MERP) index of harm.
59. In line with the national framework, all NHS boards reported that they used either the NHSScotland risk assessment matrix (18 NHS boards) or NCC MERP index (one NHS board) to carry out an initial assessment of adverse events as recommended in the framework. Out of 19 NHS boards, 18 described in their policies how these assessments could be grouped by severity into Category I, II or III events. In the policies of one special board, they did not explicitly describe grouping them as Category I, II and III events.
60. We looked at the number of adverse events being categorised as Category I events (Appendix 6). The key messages from this data are as follows.
 - On average, 1.6% of adverse events reported by acute services across Scotland were Category I.
 - Out of 19 NHS boards, 18 reported numbers of Category I adverse events that were statistically consistent with the national average. One NHS board reported a higher than expected rate of Category I events.

61. Once events have been categorised, the national framework provides a guide on the different levels of review for each category to promote a consistent national response. These are detailed as Level 1, 2 and 3 and are summarised below:
- Level 1 – significant adverse event analysis and review with full review team, using validated tools, reported through division/service governance structures with evidence of improvement plans
 - Level 2 – local management team review led by service manager with input from multidisciplinary team, reported through local governance structures with evidence of improvement plans as required
 - Level 3 – local review by line manager in discussion with staff, reported as part of aggregated reports and learning points.
62. Out of 19 NHS boards, 18 described three levels of review in line with the national framework in their policy or self-evaluation response. One NHS board (special board) described applying a Level 1 review to all its adverse events due to its small numbers.
63. The national framework provides a guide on the level of review for each event and advises that Category I events should receive a Level 1/significant adverse event review. The framework advises that there should be evidence of a process of analysis or screening being carried out to determine whether a Category I event should proceed to a Level 1 review and a clear rationale why any Category I events did not proceed to a Level 1 review. However, organisations are ultimately responsible for determining, through their own governance and decision-making arrangements, the action that should be taken following an event occurring
64. We asked NHS boards for the number of Category I events receiving a Level 1 review (Appendix 6). The data shows there is significant variation in the number of Category I events receiving a Level 1 review.
65. In order to understand possible factors contributing to this variation, we undertook teleconference meetings with each of the 19 NHS boards during May 2019. Through these discussions we sought to understand the decision-making process and checklists or tools that organisations use to consider Category I events and determine the level of review to be applied.
66. All of the 19 NHS boards described a system in place where a defined group of senior staff consider Category I events and the level of review to be applied. Examples of these groups included:

- clinical governance or patient safety group
 - an executive panel
 - directorate management team, and
 - divisional triumvirate (Medical Director, Nursing Director and Clinical Director/General Manager).
67. The national framework recommends the use of decision-making prompts to determine the level of review:
- Is the outcome a known complication of the disease, treatment or process?
 - Has there been any known breach or deviation in policy or procedure?
 - Are there unknowns surrounding the event?
 - Does the event activate duty of candour procedures?
 - Is there learning to be gained/would you do anything differently next time?
 - Is the patient, service user, family or management concerned about the event?
68. Out of 19 NHS boards, 9 reported that they use these decision-making prompts. Of the nine NHS boards that do not use these prompts, two reported that the knowledge and professional judgement of the members of their defined group supports the decision-making process. One NHS board stated that they have a robust, validated screening tool for Category I events, which is used to determine those requiring a Level 1 review. Another NHS board reported that they used a list of 'never events' based on the NHS Improvement Never Events List, and three NHS boards reported that they progress all Category I events to a Level 1 review, so do not require these prompts.
69. We asked the NHS boards where the oversight lies for the decision for the level of review applied, and how the decisions are quality assured. All 19 NHS boards told us that the oversight of the process was provided by an executive level team. In 18 of the 19 NHS boards, these groups meet weekly to review any adverse events and confirm the process has been followed correctly. The remaining NHS board told us that currently the same key members discussed adverse events over email, but may reinstate face-to-face meetings.
70. All 19 of the NHS boards told us that when a decision is made not to progress to a Level I review, they recorded a clear rationale, which is stored within the NHS board's own local reporting system.

All NHS boards reported that they use the recommended risk matrices to assess adverse events, and 18 out of 19 NHS boards described categorising these in line with the national framework.

On average, 1.6% of adverse events reported by acute services were Category I (across Scotland). Out of 19 NHS boards, 18 reported numbers of Category I adverse events that were statistically consistent with the national average. One NHS board reported a higher than expected rate of Category I events.

Out of 19 NHS boards, 18 described three levels of review for adverse events.

All NHS boards described systems and structures in place to ensure an appropriate level of review is applied. However, there is variation in the number of Category I events that receive a Level 1 review.

All NHS boards use a variety of tools, prompts and checklists to support the decision-making process to determine the level of review.

Stage 5: Review and analysis

71. Stage 5 states that reviews should be structured and consistent by using defined tools and techniques to identify contributory factors, details of the care and any lessons that could inform service improvement or reduce the risk of a similar event occurring again.
72. Details of recommended significant adverse event review tools and techniques to be used, such as 'five whys', cause and effect charts, fishbone diagrams or contributory factor frameworks, were present in 17 of the 19 NHS board policies. The two remaining NHS boards do not use recommended review tools systematically.
73. The national framework states that the review process should be quality assured to ensure it is robust and demonstrates the use of appropriate tools and techniques. Out of 19 NHS boards, 17 described having structures in place to oversee this remit such as local governance groups, corporate, senior and directorate management teams and clinical governance or clinical risk teams. One NHS board noted that quality assurance of reviews did not routinely happen and another NHS board did not describe any process for ensuring quality assurance of reviews.

74. All NHS board policies describe the roles and responsibilities of NHS board governance committees for assurance of the management of adverse events. One NHS board reported that workshops are hosted to support executive and non-executive directors fulfil their governance role. Another NHS board described a governance system review process for acute services where the top management team of the sectors and directorates are interviewed by the head of clinical governance, the medical directors and the chair of the acute clinical governance forum to check that there are robust management systems in place. Out of 19 NHS boards, 15 described their management system in their self-evaluation, or provided us with a copy of quarterly, bi-annual or annual governance reports containing information on their management of adverse events. The remaining four NHS boards reported that such information was provided to governance committees in the form of monthly theme reports, weekly reports or it forms part of the standing agenda items at committee meetings.
75. The national framework states that a report presenting the findings, conclusions and recommendations of the review should be produced and shared with everyone involved in the event.
76. Eighteen NHS boards reported that they offer the patient/family a copy of the final report, or a summary report if the main report was overly technical, with the additional offer of a face-to-face meeting to discuss the event further and explain any complexities. One special board reported that it releases a redacted version of the report, due to the sensitivity of the care they provide. One NHS board stated that it does not share reports with patients/families unless a data protection subject access request is completed.
77. Across Scotland, there are inconsistencies in how review reports and findings are shared with staff. Out of 19 NHS boards, 17 reported that they automatically share the final report with all staff involved in the adverse event. Examples include; a feedback session with staff to advise of the finding of the review, and the use of an automated function within Datix (or similar electronic reporting system), which notifies all staff involved by email that the review has concluded and provides access to the report and improvement plan. The remaining two NHS boards did not confirm if there was a process in place to routinely share reports with staff. However, one of these boards told us they use a combination of methods to advise staff of the findings and learnings from reviews. Examples of staff being involved in the factual accuracy process of the report finalisation was also outlined in three NHS board responses.

78. Appendix 3 of the national framework recommends a number of measures for NHS boards to consider to support learning and improvement. These include using a survey to seek feedback on patient, family or carer involvement and engagement with the adverse event review processes. To capture best practice around being open and duty of candour, we asked NHS boards if they had systems to routinely capture feedback from patients and families about their involvement and engagement with the review process. Out of 19 NHS boards, 15 reported that they do not have a formalised structured system in place. Instead, these NHS boards rely on informal patient/family feedback received and gathered reactively. When feedback is received, NHS boards told us this is generally positive, but, when necessary, changes are made to the adverse event management process in response.
79. NHS boards told us that gathering feedback from patients and families following an adverse event review is a sensitive and challenging area and they were keen to learn from the NHS boards who had successfully implemented a feedback system.
80. NHS boards intermittently seek feedback from staff about how they feel about their processes for managing adverse event reviews and these methods are varied. It was clear from the responses that this is done on an ad hoc basis and a lack of formal feedback mechanisms is in place. Current methods used by NHS boards to collect feedback from staff include:
- queries section on the staff intranet which allows staff to post questions
 - evaluation forms
 - one to one and group meetings, and
 - dedicated workshops.

Out of 19 boards, 17 described the validated tools and techniques used as part of their review process.

Out of 19 NHS boards, 17 described mechanisms to quality assure the review process.

All NHS boards, except one, reported that they routinely offer the family a copy of the review report along with the opportunity to meet to discuss the findings.

There is variation in how review reports and findings are shared with staff.

There is a lack of formal systems for seeking feedback from the patient, family or carer about their experiences of the process.

There is a lack of formal, consistent feedback mechanisms for staff to share their experiences of the review process.

Stage 6: Improvement planning and monitoring

81. The national framework states Level 1 and Level 2 reviews should (as required) have an improvement plan developed in response to the findings and recommendations. This should set out how each recommendation will be actioned, monitored, implemented, measured and resultant learning shared. We asked questions about the development and monitoring of improvement plans following Level 1 and duty of candour reviews and how resultant learning is shared.
82. Out of 19 NHS boards, 18 stated that this formed part of their standard adverse event management process and they have governance groups in place to oversee this or it forms part of the responsibilities of corporate, senior and directorate management teams. The 1 remaining NHS board noted this as an area of development. Seven NHS boards also reported that they use the action module of the Datix (or similar electronic reporting system) to assign actions from improvement plans to relevant people and track completion. However, there is variation in how this module is being used across NHS boards. One NHS board uses this action module to produce a report of all open actions which is sent monthly to services and has a key performance indicator for the number of actions completed. Another NHS board noted that while the action module is available across the organisation it is not routinely used, monitored or audited. This NHS board also reported that assurance groups which used to monitor progress of reviews and actions were no longer in place and that they were in the process of re-establishing them.
83. The national framework states that improvement plans should be owned locally and reviewed and updated regularly. We asked how NHS boards assure staff that these improvements are being implemented. Through the responses to the self-evaluation tool, there was less information about robust, consistent processes in place. A variety of methods were described by NHS boards:
 - five NHS boards use the actions module within Datix (or similar electronic reporting system) to send an automated update to staff involved with an adverse event
 - nine NHS boards process all improvement plans through local governance structures and give staff feedback on progress
 - one NHS board shares improvement plans with staff
 - one NHS board assures staff of improvements being implemented through the revision of policies and procedures

- two NHS boards assure staff through continued discussions and newsletters, bulletins, publication of key learning and departmental communication books, and
 - one NHS board reported that staff are assured of the process at the discretion of each directorate.
84. The national framework states that NHS boards should ensure arrangements are in place to share learning and improvements from adverse event reviews across services, the wider organisation and nationally as appropriate. All organisations outlined, through their responses to the self-evaluation tool, that learning from adverse events is routinely shared following an adverse event at both service and organisation-wide levels. For example, NHS boards have set up various operational management and executive level governance systems to support the sharing of learning from adverse events locally. Adverse events policies also contain sections which outline how learning should be shared.
85. To facilitate the sharing of learning on a local and national basis, the national framework states that NHS boards should adopt the learning summary template to share learning through the Community of Practice (CoP) website¹. Guidance to assist organisations to use this tool has also been developed. Through responses from the self-evaluation tool, it was identified that 12 out of 19 NHS boards use one-page learning summaries and five do not. The remaining two NHS boards stated that they use learning summaries intermittently, but not as standard, or as a requirement for their adverse event reviews.
86. Eight NHS boards confirmed that they upload learning summaries to the CoP website. The remaining 11 NHS boards do not do this regularly and outlined the following reasons for not doing so:
- some of the learning summaries produced by special NHS boards are not relevant to all NHS boards
 - current system/website is not robust
 - the level of redaction required to anonymise reports made the final report/summary difficult to read or use
 - concern around media focus of any adverse event cases
 - limited awareness amongst staff of the CoP website, and
 - unsure of benefit, and enquired as to whether other NHS boards are accessing the data it contains.

Two of the NHS boards who do not upload learning summaries do make use of the COP website to access resources and review the shared learning summaries.

¹ <http://www.knowledge.scot.nhs.uk/adverse-events/adverse-events-toolkit.aspx>

87. All NHS boards reported other methods for sharing learning nationally, for example national groups (such as the adverse event network), patient safety networks, Datix user groups, national and local conferences and the Excellence in Care programme.
88. The national framework states thematic learning should be collated over time to assist and inform wider improvement programmes. All NHS boards described their systems in place to collate and review learning to identify themes. A variety of methods are used across Scotland such as:
- review of adverse events reports and improvement plans through divisional clinical governance groups to identify themes
 - reporting of these themes through wider clinical governance reporting structures up to NHS board level for wider organisational sharing of learning
 - submission of all significant adverse event review learning summaries to practice and professional development units
 - themes identified for wider learning discussed at inter-specialty clinical governance meetings, and
 - discussion about adverse event outcomes at morbidity and mortality meetings and other forums.
89. The national framework states that evaluation should take place to evidence that changes, made as a result of improvement plans from adverse event reviews, have led to sustainable improvements that minimise the risk of recurrence. All of the NHS boards reported that oversight for this came from clinical governance or risk management groups. However, there was no clear, standardised process or method used by NHS boards to carry out this evaluation and it was highlighted as a challenge. Four of the 19 NHS boards explicitly stated that this was an area requiring development, as the evidence supporting their improvements was not currently robust. In one response, the NHS board asked for national support and guidance to achieve this.
90. The national framework states that systems should be in place to effectively and efficiently capture, analyse and report on data from a variety of sources. Organisations should scrutinise adverse event data alongside data from complaints, claims and patient feedback to assure themselves that their organisation learns, takes action and monitors the impact.
91. Overall, through their responses to the self-evaluation tool, NHS boards have set up various systems and processes to meet this element of the national framework. The improvement planning and monitoring process is normally carried out at executive management level and includes membership from clinical and risk management groups. These meetings take place routinely and all available data sources from across the NHS board are reviewed to provide a

whole systems approach. NHS boards also highlighted the use of Datix (or similar electronic reporting system) in order to collate the data to inform these meetings.

All NHS boards reported that they have operational, management and governance structures and groups in place to oversee the development and implementation of improvement plans.

There is variation in the processes to assure staff that improvements are being implemented.

All NHS boards described systems and tools in place to support sharing learning locally, with 12 out of 19 NHS boards using the HIS learning summary template.

There is variation in the use of the HIS Community of Practice (CoP) website and in the perceived benefits of using this as a forum to share learning nationally.

All NHS boards described systems and processes to identify themes from learning – the level of scrutiny around this varies from operational to NHS board-wide governance structures.

Evaluating the impact of changes on patient outcomes and demonstrating sustained improvements as a result of improvement plans is a challenge in many NHS boards.

All NHS boards reported that they have processes and structures in place to review data from a variety of sources and take action and monitor this.

Additional information

92. Appendix 3 of the national framework outlines suggested measures for NHS boards to consider as part of measurement and monitoring of their processes for managing adverse events for governance purposes and for learning and improvement. The responses to the self-evaluation tool demonstrate variation in the measures being collected: from all measures being collected to only one or two measures being collected.
93. We identified a number of challenges faced by NHS boards when collecting their adverse events management data, including limitations of data capturing systems, capacity and capability of staff in collecting, presenting and analysing data for improvement, and the implementation of review timescales (for example, during a review process, when does the 'clock' start).
94. We also asked NHS boards how they have engaged and collaborated with colleagues in primary care, secondary care and social care to move towards a more consistent approach to reporting and learning from adverse events. Through the responses to the self-evaluation tool, it was identified that this engagement and collaboration has been implemented at varying degrees across Scotland. One NHS board described being at a more advanced stage of health and social care integration compared to other NHS boards in Scotland. Overall, it was highlighted that some positive steps have been taken to date, but a consistent approach to the management of adverse events across all aspects of health and social care settings is still at an early stage. Some examples of NHS board progress in this area are as follows:
 - multidisciplinary groups created, with membership across health and social care to discuss and disseminate learning from adverse events
 - GP involvement in local medicine safety groups
 - development of Datix lite to encourage reporting of adverse events in primary care
 - workshops and newsletters to inform other care settings, and
 - a pilot project to explore the establishment of a primary and secondary care interface group, with a focus on learning from adverse events and improvement to patient pathways.

95. NHS boards also provided the following examples of some of the barriers faced when attempting engagement and collaboration with primary and social care colleagues:

- adverse event reviews are not consistently handled across primary care since they fall within the remit of individual practices as independent contractors
- currently no link with health and social care partnerships for adverse events, due to the use of two unconnected electronic reporting systems, and
- improvement group meetings set up between NHS board and primary care but no involvement from the health and social care partnership.

NHS boards use a variety of measures (based on Appendix 3 of the national framework) to monitor their local adverse event process.

A consistent approach to the management of adverse events across all aspects of health and social care settings is still at an early stage and engagement with primary, secondary and social care colleagues is variable. Some NHS boards have built these relationships and support them with systems and processes, whilst many NHS boards view this as an area for development.

Experience of implementing the national framework

96. NHS boards provided feedback on their experience of implementing the national framework, including successes and challenges. They also gave us feedback on any perceived gaps within the current version of the national framework.
97. Overall, feedback on the current version of the framework was very positive, with NHS boards describing it as a useful and comprehensive source of guidance. NHS boards also stated it was a useful tool to enhance and strengthen existing adverse events management policies.
98. The current version of the national framework contains revised timelines for the review of adverse events which were reported by NHS boards as being easier to achieve. However, some NHS boards reported that they continue to struggle to achieve the timelines. Other challenges that NHS boards described in implementing the national framework were as follows:
 - continued difficulties to gather feedback and evaluations from patients, families and carers
 - the increasing burden on staff around the administration and bureaucracy required when managing adverse events reviews alongside existing job demands
 - current categorisation of adverse events is challenging, and
 - understanding and application of duty of candour.
99. With regards to any future updates to the national framework, NHS boards suggested the following areas could be developed:
 - national approach to the application of duty of candour
 - consultation with healthcare professionals to inform the next version of the framework
 - introduction of an electronic learning summary
 - clearer guidance on the development and implementation of improvement plans
 - report sharing guidance, and
 - guidance in relation to continuing to share information with patients, families and carers when a claim has been submitted.

Key priorities described by NHS boards

100. We asked NHS boards about key areas for improvement and key priorities for delivering a robust and effective system for managing adverse and duty of candour events. From the self-evaluation tools submitted by NHS boards, the following key themes were identified.

Key priority 1: Feedback and evaluation

101. A requirement to develop mechanisms which allow NHS boards to gather feedback from staff, patients, families and carers was noted frequently in responses to this question. NHS boards seek to review and expand their current communications strategies to provide a better understanding of how people feel about their adverse events management systems. This would be achieved by developing and implementing a robust system and process to gather feedback and evaluation. This information would then be used to support improvements in processes, staff training and provide assurance to staff, patients, families and carers that all adverse events are reported, categorised and reviewed in line with the national framework. A consideration of the use of safety climate surveys to provide NHS boards with an understanding of the perception of the organisation's safety culture was also reported to us as a useful tool to enable feedback and evaluation from staff.

Key priority 2: Quality management

102. NHS boards highlighted a need to continue to review and develop their policies and procedures for the management of adverse events and duty of candour to embed a quality assurance system that gives people confidence in the quality and sustainability of the system and supports improvements in patient outcomes. Particular areas of focus highlighted were:

- embedding a consistent approach to duty of candour events
- robust governance of adverse event reviews, and
- embedding quality reporting (aligned to the HIS quality of care framework).

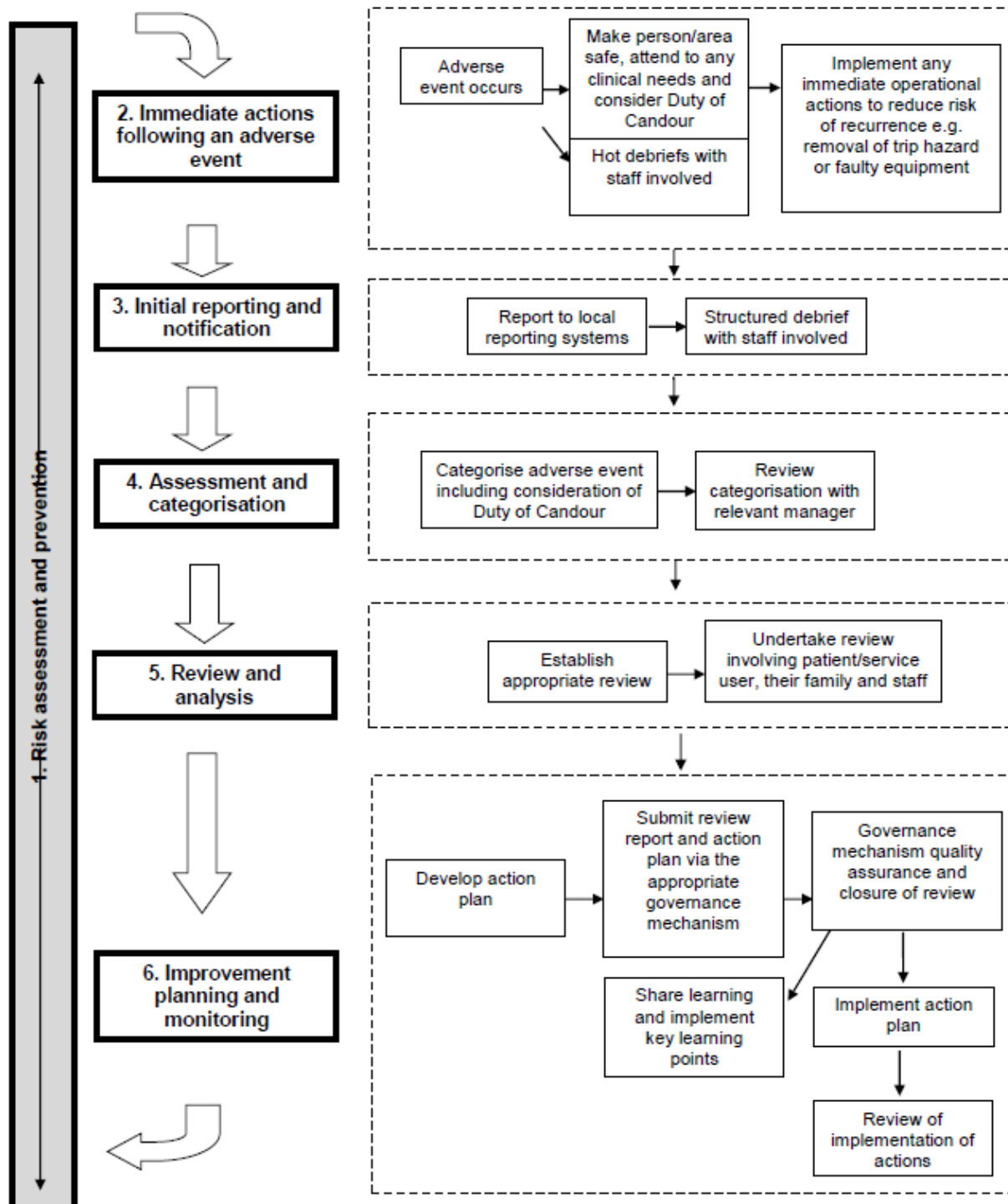
Key priority 3: Monitoring of improvement plans

103. Organisations reported a need to develop and implement robust systems and processes that assure the effective monitoring, management and implementation of improvements resulting from adverse event reviews. It was highlighted by NHS boards that current processes could be simplified in order to identify improvement themes across services.

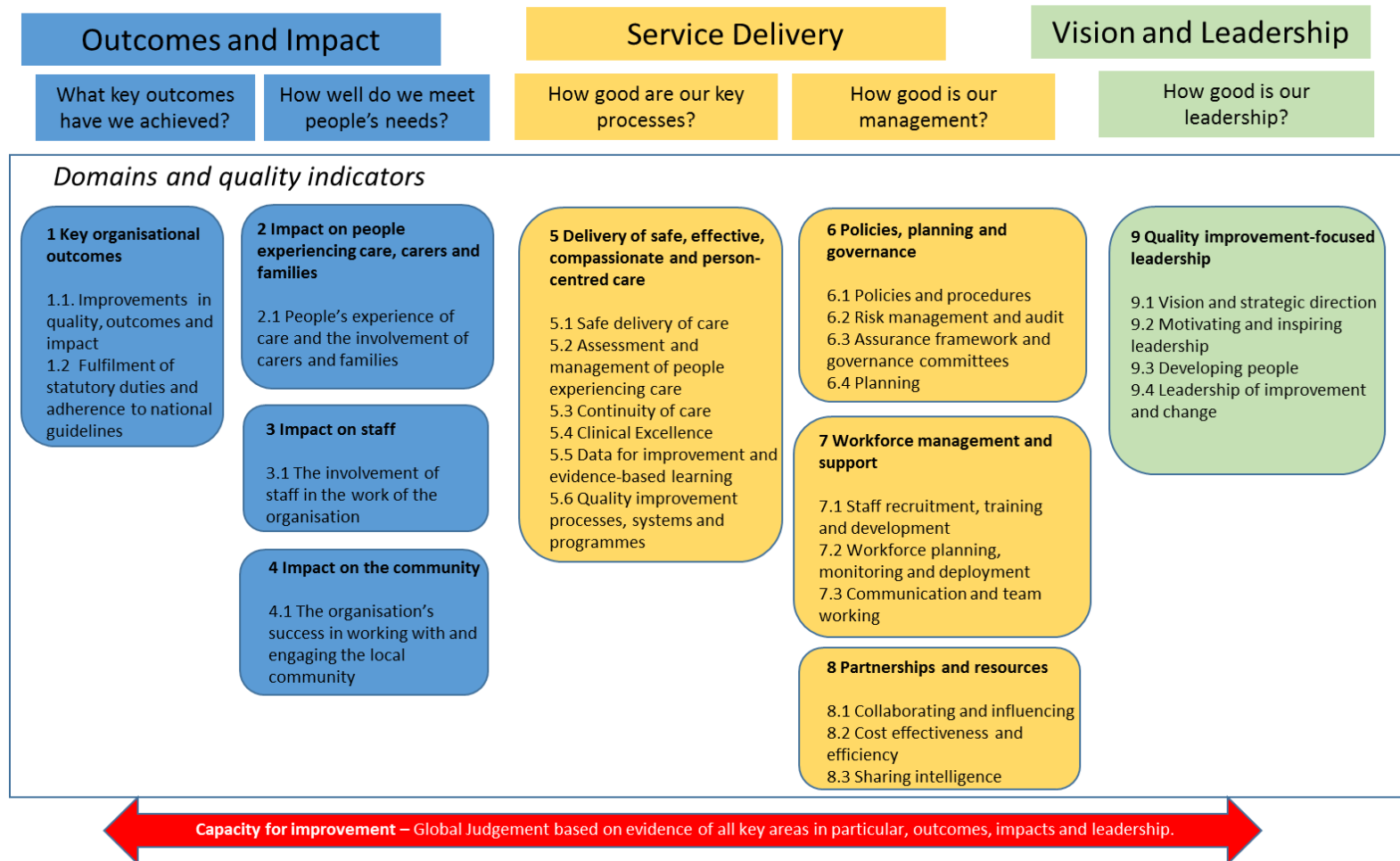
Key priority 4: Sharing learning

104. A consistent message from NHS boards was a need to improve how they share learning both locally and nationally. Organisations highlighted the requirement for the development of robust mechanisms and processes at a national level that support existing reporting systems to effectively share learning and continually support a culture of continuous improvement to implement that learning.

Appendix 1 – Six stages of adverse event management



Appendix 2 – Quality framework outline structure



Appendix 3 – Self-evaluation tool



Quality of Care Approach

Quality of Care – Adverse Events Baseline Exercise

Self-evaluation Tool

November 2018

Background to the exercise

The Health and Sport Committee published a report on [The Governance of the NHS in Scotland - ensuring delivery of the best healthcare for Scotland](#) in July 2018. This report contained commentary and recommendations regarding the management 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.

We are executing this by tailoring our Quality of Care Approach self-evaluation tool to request information specific to the management of adverse events involving patients. This information will be used for 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 ihub¹ portfolio, and
- to identify areas of good practice and areas of challenge

Quality of care approach

The quality of care approach aims to bring consistency to Healthcare Improvement Scotland's external quality assurance work and to support service providers to evaluate their own care delivery. The approach includes a framework, called the '[Quality Framework – Evaluating and improving healthcare](#)', to guide people through this evaluation.

This self-evaluation tool has been developed to enable organisations to self-evaluate their performance against nine areas of focus, called domains, which are outlined within the Quality Framework. For the purposes of this baseline exercise we have reduced the areas of focus to those domain areas most relevant to the management of adverse events involving patients.

¹ The ihub (Improvement Hub) is part of Healthcare Improvement Scotland. It supports health and social care organisations to redesign and continuously improve services.

Self-evaluation context

Organisation name:

Named contact:

Telephone:

Email:

Please provide the name of a person and contact details so that Healthcare Improvement Scotland can contact your organisation with any queries regarding your completed response.

Please provide us with the following relevant contextual and background information about the organisation.

Please provide a copy of or highlight a link to where the following may be found:

- Policies/procedures for risk management and the management of adverse events that align with the national framework and duty of candour legislation.
- Annual report that includes information on your management of adverse events (if applicable).

Please complete the following tables and questions:

Table 1: Categorisation and levels of Reviews within your organisation/s

	Question	Response
1	What electronic reporting system do you use for adverse events?	
2	In this system, what categories do you use to record the severity of an adverse event? (e.g. National Framework, NHS Scotland Risk Assessment Matrix etc.)	
3	How do you describe/distinguish the different levels of review for adverse events and duty of candour within your organisation/s? (e.g. significant adverse event, serious clinical incident, team, manager etc.)	

Table 2: Numbers of reviews and level within your organisation

	Number of clinical (patient) adverse events reported between 1 Oct 17 – 1 Oct 18	Acute care			Health and Social Care Partnership/s (Please include all aspects of primary care and general practice)		
1	Level of Review Carried out or please insert locally defined equivalent as per question 2 and 3 above	L1	L2	L3	L1	L2	L3
	Total number of clinical (patient) adverse events						
	Category 1 events						
	Category 2 events						
	Category 3 events						
2	Number of Duty of Candour (DoC) events recorded between 1 April 2018 – 1 October 2018 (include a breakdown of the category these were assigned)						
3	If there are any areas within your organisation where data for Table 2 is not collated or recorded, please list these areas opposite (eg community hospital, general practice, community pharmacy, district nursing, health visiting, etc)						

For each of the following quality of care domains, please provide a succinct narrative outlining how your organisation is performing in relation to adverse events and duty of candour, how you are assured of this and what you need to do better or differently.

The narrative should focus on the impact and outcomes on those accessing healthcare services. This should include examples that demonstrate the impact of improvements made for those who use or deliver healthcare services.

The accompanying guide to [self-evaluation](#) provides further information on how best to complete this self-evaluation tool.

Domain 1: Key organisational outcomes

<p>Q. How are you doing in respect of embedding and sustaining improvement in quality of care and achieving the best possible outcomes for service users from your reviews of adverse events?</p> <p>Include reference to strengths, good practice and key challenges. See the themes and 'factors to consider' in the Quality Framework to help shape your answer.</p> <p>1.1 How do you share learning from reviews across the NHS board and collate and review this learning to identify themes?</p> <p>1.2 Do you create one page learning summaries and please describe your criteria for producing them? If you do not produce these, why do you choose not to do so and what alternative do you have in place?</p> <p>1.3 Have you shared any learning summaries on the Adverse Events Community of Practice (AE CoP) website? Please describe any barriers to sharing and/or gaining learning on this forum?</p> <p>1.4 What other methods have you used to share learning nationally?</p> <p>1.5 How do you evaluate if changes made as a result of improvement plans from significant adverse event reviews have resulted in sustainable change/improvement to minimise the risk of reoccurrence/improve outcomes locally and nationally?</p>
<p>Q. How do you know this?</p> <p>1.6 Within the management of adverse events, can you give examples of quality improvements have been implemented that have led to improved patient outcomes?</p>
<p>Q. What do you need to do better or differently?</p> <p>1.7 What are the key next steps to ensure patient outcomes are improved from the management of adverse events?</p> <p>1.8 What are the next steps to ensure you are compliant with all aspects of the adverse events framework?</p> <p>1.9 What improvement would you like to see in your management of adverse events system, one year from now, that is currently not being achieved?</p>
<p>Any further comments about key organisational outcomes?</p>

Domain 2: Impact on people experiencing care, carers and families

<p>Q. How are you doing in respect of support for people experiencing care, carers and families, following an adverse event and the statutory Duty of Candour?</p> <p>Include reference to strengths, good practice and key challenges. See the themes and 'factors to consider' in the Quality Framework to help shape your answer.</p> <p>2.1 How do you ensure people experiencing care, carers and families have all the information that they need following adverse events including those that activate DoC?</p> <p>2.2 How do you support the active and planned engagement with people experiencing care, carers and families affected by significant adverse events and DoC in the review process?</p> <p>2.3 How are review reports shared with people experiencing care, carers and families involved in a significant adverse or DoC event?</p>
<p>Q. How do you know this?</p> <p>2.4 Can you demonstrate that people experiencing care, carers and families have confidence in your process for managing adverse events?</p> <p>2.5 Can you show examples of feedback from people care, carers and families being used to:</p> <ul style="list-style-type: none"> • improve the process for managing adverse events • inform improvements from adverse events?
<p>Q. What do you need to do better or differently?</p>
<p>2.6 What are the key next steps or areas for improvement that the organisation/s needs to take forward to improve the impact on people experiencing care, carers and families within the management of adverse events?</p>
<p>Any further comments about impact on people experiencing care, carers and families?</p>

Domain 3: Impact on staff and Domain 9: Quality improvement-focused leadership

<p>Q. How are you doing in respect of support for staff involved in adverse events and Duty of Candour?</p> <p>Q. How does your leadership promote an open and just organisational culture to reporting and learning from adverse and Duty of Candour events?</p>
<p>Include reference to strengths, good practice and key challenges. See the themes and 'factors to consider' in the Quality Framework to help shape your answer.</p> <p>3.1 Can you demonstrate an effective safety culture where staff are confident and empowered with knowledge and skills to report and respond effectively to adverse and DoC events? How do you support staff following an adverse event or DoC event?</p> <p>3.2 How do you ensure effective training / education for staff leading adverse event and DoC reviews and for those participating in review teams?</p> <p>3.3 How do you include and support staff involved in the adverse event or DoC in the review process?</p> <p>3.4 How are review reports/findings and subsequent improvement plans shared with staff involved in a significant adverse or DoC event?</p> <p>3.5 How can staff be assured that recommendations following adverse events will be implemented?</p>
<p>Q. How do you know this?</p>
<p>3.6 What evidence do you have about how staff feel about your process for managing adverse events and is the evidence up to date?</p> <p>3.7 Can you demonstrate feedback from staff being used to improve the management of adverse events?</p>
<p>Q. What do you need to do better or differently?</p>
<p>3.8 What are the key next steps or areas for improvement the organisation needs to take forward in improving the impact on staff and quality improvement-focused leadership from the management of adverse events?</p>
<p>Any further comments about impact on staff and quality improvement-focused leadership?</p>

Domain 5: Delivery of safe, effective, compassionate and person-centred care

Q. How are you doing in respect of safe, effective, compassionate and person-centred care delivery in relation to adverse events and Duty of Candour?

Include reference to strengths, good practice and key challenges. See the themes and 'factors to consider' in the Quality Framework to help shape your answer.

5.1 What systems, processes, meetings are in place that would allow the board to identify similar themes and issues from a variety of data sources such as; adverse events, DoC events, complaints, claims, patient feedback, person centred care and quality improvement programmes?

5.2 How have you engaged and collaborated with colleagues in primary care, secondary care and social care to move towards a more consistent approach to reporting and learning from adverse events?

5.3 Do you collect data on any of the local measures suggested in Appendix 3 of the national framework? If so, where is this information discussed and how is it used for improvement? What challenges have you faced in measuring data?

Q. What do you need to do better or differently?

5.4 What are the key next steps or areas for improvement the organisation needs to take forward in improving safe, effective, compassionate and person-centred care delivery in relation to adverse events and DoC?

Any further comments about safe, effective, compassionate and person-centred care delivery in relation to adverse events and DoC?

Domain 6: Policies, planning and governance

Q. How are you doing in respect of policies, planning and governance for the management of adverse events?

Include reference to strengths, good practice and key challenges. See the themes and 'factors to consider' in the Quality Framework to help shape your answer.

6.1 How is the effectiveness and implementation of policies and procedures assessed and improved?

6.2 How do you ensure an appropriate level of review for each category of adverse events and whether an adverse event activates the duty of candour?

6.3 How do you ensure quality assurance of adverse events and DoC reviews?

6.4 How do you ensure that level 1 (significant adverse event) and DoC reviews have:

- an improvement plan developed in response to the findings and recommendations
- that these improvement plans routinely set out how each recommendation from the review will be actioned, monitored, implemented and measured, and
- that resultant learning is shared and includes responsible owners, timescales for delivery and review dates?

6.5 How do you ensure that your governance structures provide appropriate assurance of safe, effective, compassionate and person-centred care delivery?

Q. What do you need to do better or differently?

6.6 What are the key next steps or areas for improvement the organisation needs to take forward in improving policies, planning and governance for the management of adverse events?

Any further comments about policies, planning and governance?

Summary of priorities

Q. Having reflected on all domains, what are your overall three key priorities for delivering a robust and effective system for managing adverse and DoC events?

1.

2.

3.

National framework for learning from adverse events through reporting and review

Please use the box below to highlight your views on your experience of implementing the national framework including successes and challenges, any perceived gaps in the framework and what would you like to see addressed in future versions of the framework.

Healthcare Improvement Scotland

Edinburgh Office

Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

0131 623 4300

Glasgow Office

Delta House
50 West Nile Street
Glasgow
G1 2NP

0141 225 6999

www.healthcareimprovementscotland.org

Appendix 4 – List of patient-facing NHS boards

The self-evaluation tool was sent out to the Chief Executives and Liaison Co-ordinators of all patient-facing NHS boards. Responses were received from all 19 NHS boards. The NHS boards involved in the self-evaluation are listed below: 14 of these organisations are regional NHS boards and five are special boards.

Regional NHS boards

- NHS Ayrshire & Arran
- NHS Borders
- NHS Dumfries & Galloway
- NHS Fife
- NHS Forth Valley
- NHS Greater Glasgow and Clyde
- NHS Grampian
- NHS Highland
- NHS Lanarkshire
- NHS Lothian
- NHS Orkney
- NHS Shetland
- NHS Tayside
- NHS Western Isles

Special boards

- NHS 24
- NHS National Services Scotland
- Golden Jubilee National Hospital
- Scottish Ambulance Service
- The State Hospitals Board for Scotland

Appendix 5 – National overview

Stage	Stage 1: Risk assessment	Stage 2: Identification, immediate action	Stage 3: Reporting and notification	Stage 4: Assessment and categorisation				Stage 5: Review and analysis				Stage 6: Improvement planning and monitoring			
NHS board Key action	Definition	Patients, families and carers and support for staff	Training and education	Risk matrices	Categorise in line with framework	Three levels of review	Systems to ensure appropriate level of review	Review QA	Report shared with family	Report shared with staff	Consistent approach to patient feedback for evaluation	Development and monitoring improvement plans	Local learning	National learning	Regular use of CoP
NHS Ayrshire & Arran	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NHS Borders	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✗
NHS Dumfries & Galloway	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗
NHS Fife	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓
NHS Forth Valley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓
NHS Greater Glasgow and Clyde	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗*	✓	✓	✓	✓

* NHS Greater Glasgow and Clyde has tested the final meeting with the patient/family as a feedback mechanism. They are currently exploring methodologies for a formal structured approach.

NHS board Key action	Definition	Patients, families and carers and support for staff	Training and education	Risk matrices	Categorise in line with framework	Three levels of review	Systems to ensure appropriate level of review	Review QA	Report shared with family	Report shared with staff	Consistent approach to patient feedback for evaluation	Development and monitoring improvement plans	Local learning	National learning	Regular use of CoP
NHS Grampian	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓	✓	✓	✗
NHS Highland	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓
NHS Lanarkshire	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗
NHS Lothian	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓	✓	✓	✓
NHS Orkney	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓
NHS Shetland	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✗
NHS Tayside	✓	✓	✓	✓	✓	✓	✓	✓	✗~	✓	✗	✓	✓	✓	✓
NHS Western Isles	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✗	✓	✓	✓

~ Review report only shared if an official request has been made.

NHS board Key action	Definition	Patients, families and carers and support for staff	Training and education	Risk matrices	Categorise in line with framework	Three levels of review	Systems to ensure appropriate level of review	Review QA	Report shared with family	Report shared with staff	Consistent approach to patient feedback for evaluation	Development and monitoring improvement plans	Local learning	National learning	Regular use of CoP
NHS 24	✓	✓	✓	✓	✓	✗†	✓†	✓	✓	✓	✗	✓	✓	✓	N/A**
NHS National Services Scotland	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	N/A**
Golden Jubilee National Hospital	✓	✓	✓	✓	✗^	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓
Scottish Ambulance Service	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	N/A**
The State Hospitals Board for Scotland	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✗

† All adverse events receive a level 1 review

** Given the context and setting, the learning can be service specific and therefore not always relevant to share on the CoP.

^Reporter/ reviewer is not asked to categorise but confirms the severity grading and level of review; categorisations is supported by Clinical Governance Department

Appendix 6 – NHS board adverse event data (acute clinical data only)

It is not possible to directly compare NHS boards' data on the number of Category 1 adverse events (acute clinical). In order to promote learning, some NHS boards record certain adverse events as Category I events even though these are not part of the national framework Category I definition. This may include events such as pressure ulcers already present on admission, all deaths in hospital, all cardiac deaths, inpatient falls resulting in harm; any list of additional events included in the numbers of Category I events will vary across NHS boards.

NHS board	Total number adverse events (acute clinical)	Category I adverse event (acute clinical)	Category I with Level 1 Review/SAER (acute clinical)
Territorial boards			
NHS Ayrshire & Arran	3,710	41 (1.1%)	10 (24.4%)
NHS Borders	2,006	32 (1.6%)	9 (28.1%)
NHS Dumfries & Galloway	1,395	29 (2.1%)	13 (44.8%)
NHS Fife	4,990	293 (5.87%)	9 (3%)
NHS Forth Valley	4,995	64 (1.25%)	small numbers
NHS Grampian	7,461	10 (0.13%)	10 (100%)
NHS Greater Glasgow and Clyde	25,825	507 (1.96%)	140 (27.61%)
NHS Highland	10,309	107 (1%)	53 (50%)
NHS Lanarkshire	9,393	71 (0.76%)	33 (46%)
NHS Lothian	10,986	290 (2.64%)	219 (75.52%)
NHS Orkney	55	small numbers	small numbers
NHS Shetland	231	small numbers	small numbers
NHS Tayside	5,298	69 (1.3%)	46 (67%)
NHS Western Isles	490	small numbers	small numbers
Special boards			
NHS 24	10	small numbers	small numbers
National Services Scotland	160	small numbers	small numbers
National Waiting Times Centre	815	small numbers	small numbers
Scottish Ambulance Service	1,328	10 (0.75 %)	10 (100%)
State Hospital Board	1,444	small numbers	small numbers

Where the number of adverse events is between zero and five, the above table has been edited to state 'small numbers'. This is to avoid the risk of disclosure of patient identification.

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