Management of adverse events

Review Report | NHS 24
December 2013
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Executive summary

In June 2012, Healthcare Improvement Scotland published a report called: The Management of Significant Adverse Events in NHS Ayrshire & Arran (2012). The report provides an in-depth analysis of NHS Ayrshire & Arran's adverse event management system and outlines a number of recommendations and issues that the NHS board should act on. The report also contains recommendations for other NHS boards in Scotland and learning points for NHSScotland as a whole.

Immediately following the publication of our report, the Cabinet Secretary for Health, Wellbeing and Cities Strategy asked Healthcare Improvement Scotland to carry out a rolling programme of reviews across NHS boards starting in autumn 2012.

Our reviews focus on the six key recommendations for NHS boards (numbers 18–23) from the NHS Ayrshire & Arran report. The purpose of the reviews is to assess how investigation of adverse events is being used by NHS boards to drive learning and improvement in order to reduce the risk of these events occurring again.

What we found

Our review of NHS 24's governance arrangements and processes for managing adverse events involved:

- an analysis of evidence provided by the NHS board, and
- a visit to NHS 24 on Thursday 31 October 2013.

NHS 24 has processes and systems in place for the management of adverse events. This includes the use of the electronic system, RESPOND, to record adverse events, partner feedback and complaints. NHS 24 has recently undertaken a comprehensive review of its adverse event management process. It initiated the review in response to the NHS Ayrshire & Arran report findings and to help inform the development and implementation of a new system to replace RESPOND.

The new system, iCaseworks, will capture all information and documentation relating to adverse events, complaints and partner feedback within a single database. The new system forms part of a significant service redesign programme of work, called the ‘future programme’. NHS 24 has developed an improvement plan outlining its current position against the NHS Ayrshire & Arran review recommendations and proposed changes to improve the service. This plan takes into account the learning from all the NHS board management of adverse events review reports published to date by Healthcare Improvement Scotland. We recognise the challenge facing NHS 24 in introducing a new system and redesigning services to take forward improvements.

We noted the following areas of good practice within NHS 24:

- a robust governance structure for the management of adverse events
- comprehensive investigation teams that involve relevant specialties where required
- standard templates for validating adverse incidents and compiling investigation reports, using the situation, background, action and recommendations format
- follow-up of action plans to make sure actions are completed
- documented one-to-one sessions with staff which include reflective practice, and
• an organisational culture that is open to change, with a focus on learning and improving from adverse events.

The review team identified areas which NHS 24 should improve to ensure consistent management of significant adverse events. These include: patient and family engagement, feedback to staff, staff input to action plan development, timely investigations and the sharing of learning. The recommendations below aim to support this.

**Recommendations**

We expect NHS 24 to continue to implement recommendations 18–23 from the NHS Ayrshire & Arran report. We have also identified the following associated recommendations to improve how the NHS board manages adverse events.

**Engaging with stakeholders**

*Recommendation 18 from the NHS Ayrshire & Arran report*

*NHS boards should ensure that they are taking an active and planned approach to engaging with key stakeholders particularly the patients, family and carers affected by a significant adverse event.*

NHS 24’s active and planned approach to engaging with key stakeholders affected by a significant adverse event should:

1. always consider involving patients and family in the investigation process. If involvement does not take place, NHS 24 should record the rationale for not doing so
2. introduce a process to demonstrate that staff are actively involved throughout the investigation process, including identifying issues for consideration, and they receive appropriate feedback and updates on progress and outcomes, and
3. ensure staff involved in a patient safety incident receive a copy of the investigation report for comment and have input into the development of the action plan, where appropriate.

**Staff knowledge and training**

*Recommendation 19 from the NHS Ayrshire & Arran report*

*NHS boards should ensure that their staff are trained and have suitable knowledge and understanding to be involved and contribute to the full management of significant adverse events including the implementation of actions relating to learning, change and improvement.*

To support staff knowledge and training, NHS 24 should:

4. provide up-to-date investigation training or refresher courses for key staff involved in investigations to ensure a consistent approach when reviewing adverse events.
Roles and responsibilities

Recommendation 20 from the NHS Ayrshire & Arran report

NHS boards should ensure that all members of staff have a clear understanding of their roles and responsibilities regarding significant adverse events and that clear lines of accountability are defined and reflective of the organisation’s governance structure.

We did not identify any recommendations for this section.

Information management

Recommendation 21 from the NHS Ayrshire & Arran report

NHS boards should ensure that their document control and related information systems are suitably integrated and robust to provide a complete audit trail of significant adverse event management from the incident occurring to evidencing change and improvement. These systems should also allow NHS boards to undertake ongoing thematic learning from significant adverse events.

To support its information management processes, NHS 24 should:

5 introduce a process to demonstrate that all documentation relating to a patient safety incident is stored in a secure central location with evidence of final version control.

Risk-based, informed and transparent decision-making

Recommendation 22 from the NHS Ayrshire & Arran report

NHS boards should ensure that the decisions related to the management of significant adverse events are risk based, informed and transparent to allow appropriate level of scrutiny and assurance.

To support a risk-based, informed and transparent approach, NHS 24 should:

6 continue to implement plans to standardise the investigation function to ensure a consistent process for investigating patient safety incidents, whether they arise through partner feedback, complaints or potential adverse events.

Timely management, learning, dissemination and implementation

Recommendation 23 from the NHS Ayrshire & Arran report

NHS boards should ensure that the management of significant adverse events is completed in a timely manner and that the thematic learning is appropriately disseminated and acted upon throughout the organisation.

To improve timely management, learning and dissemination following adverse events, NHS 24 should:

7 strengthen the process for monitoring patient safety incident investigation timescales, review reasons for any delays and ensure timescales are met, and
provide more detailed learning messages to staff including information on the context, how the learning was identified, and why improvements are being implemented.

We have asked the NHS board to develop an improvement plan to address the identified recommendations.

We would like to thank NHS 24 and in particular the staff involved in our discussions during the review.
1 Introduction

1.1.1 An adverse event can be described as an unexpected or avoidable event that could have resulted, or did result in, unnecessary serious harm or death of a patient, staff, visitors or members of the public. Reviewing and managing these events should help NHS boards learn how to reduce the risk of them happening again.

1.1.2 We published a report in June 2012 called: *The Management of Significant Adverse Events in NHS Ayrshire & Arran*. The report focuses on NHS Ayrshire & Arran’s adverse event management system but also contains recommendations for other NHS boards in Scotland and learning points for NHSScotland as a whole.

1.1.3 Immediately following the publication of our report, the Cabinet Secretary for Health, Wellbeing and Cities Strategy asked us to:

- develop a national approach to learning from adverse events, and
- carry out a rolling programme of reviews across NHS boards starting in autumn 2012.

The review process

1.1.4 Reviewing NHS boards’ governance arrangements and processes for managing adverse events helps us to identify whether appropriate learning and improvement is taking place to reduce the risk of events happening again.

1.1.5 Our reviews focus on the six key recommendations (18–23) for NHS boards from the NHS Ayrshire & Arran report (2012) to provide assurance that NHS boards are effectively managing adverse events. We measure NHS boards against the recommendations within the NHS Ayrshire & Arran report and against their own policies.

1.1.6 The review process has two key phases:
- pre-visit analysis, and
- the review visit.

Pre-visit analysis

1.1.7 We reviewed information provided by NHS 24 in advance of the visit. This included:
- policies and procedures for adverse event management
- governance and reporting arrangements
- an assessment of the NHS board’s current and future planned approach following the recommendations of the NHS Ayrshire & Arran report
- a list of six recorded significant adverse events over the past 18 months, and
- details of four specific significant adverse event reviews.
1.1.8 Of the six recorded significant adverse events, we selected four cases for detailed review. We did this by reviewing the high level summary of each case, taking into account the location and specialty of the event and the level of investigation.

Review visit
1.1.9 The review visit took place on Thursday 31 October 2013. The review team was made up of a number of individuals with relevant specialist knowledge from across Scotland (see Appendix 1 for membership of the review team).

1.1.10 During the visit, we had discussions with a range of staff from senior management to frontline operational staff to assess how adverse events are managed in practice.

1.1.11 We discussed the initial findings of our report with NHS 24’s chief executive on 25 November 2013.

Improvement plan
1.1.12 We expect NHS 24 to continue to implement recommendations 18-23 from the NHS Ayrshire & Arran report and to implement the specific recommendations within this report. It is important that the recommendations are carefully considered and a detailed improvement plan developed, with appropriate timescales, ownership, accountability and measures incorporated.

1.1.13 We have asked NHS 24 to keep us updated as the improvement plan progresses and to notify us when it has been agreed by local governance structures. This will inform the development of the national approach to learning from adverse events.
2 NHS 24’s adverse event management policies and procedures

2.1.1 NHS 24 is a special health board providing a national health service to people in Scotland through telephone, web and other digital channels. NHS 24 provides an online and out-of-hours phone service 24 hours a day, every day of the year. It has four major regional contact centres in Clydebank, Glasgow; Cardonald, Glasgow; South Queensferry, Edinburgh; and on-site at Aberdeen Royal Infirmary. NHS 24 also has local centres in most NHS board areas across Scotland.

2.1.2 NHS 24 works closely with NHS boards and the Scottish Ambulance Service to provide services to patients in need of urgent clinical advice when their GP practice is closed. NHS 24 also provides comprehensive health information and self-care advice for people across Scotland.

Adverse event definitions

2.1.3 Adverse events within NHS 24 are known as patient safety incidents. All patient safety incidents are graded using a risk matrix. Those that are graded as major or extreme are considered to be significant adverse events.

2.1.4 NHS 24’s policy for managing adverse events includes the following definitions:

“A patient safety incident is an event or circumstance that could have or did lead to unintended or unexpected harm, loss or damage.

“A near-miss is any situation that could have resulted in an incident, but did not due to either chance or intervention.”

2.1.5 All deaths within 48 hours of contacting NHS 24 are treated as potential patient safety incidents. Staff are required to follow the adverse event management process in these instances.

2.1.6 NHS 24 has identified four overall themes arising from adverse event reviews. The themes include elements of the following:

- clinical content of algorithms
- call streaming process
- individual learning for staff, and
- use of operational clinical processes.

Policy for managing adverse events

2.1.7 NHS 24 has a comprehensive patient safety incident guidance document. This was introduced a number of years ago and is currently at version 3.1. This document is hereafter referred to as ‘the policy’. The policy provides guidance on the adverse event management process, including information on:

- incident validation
- notification
- the investigation team
• clinical development team
• reporting
• people management
• interviews
• support for staff
• root cause analysis
• investigation tools
• incident grading
• learning from experience
• record storage
• roles and responsibilities, and
• sharing of information.

2.1.8 The policy also contains a patient safety incident flow chart and an incident decision tree to help guide staff through the process.

2.1.9 The policy includes the following statement:

“In a service as complex as NHS 24, things will sometimes go wrong. When they do, the response must be geared to reducing both the risks for patients and the staff. The systematic reporting of incidents is paramount to quality improvement. Patient Safety Incident and near miss reporting:

• allows the identification of incidents to investigate further, using root cause analysis in order to pinpoint the causes of specific incidents.
• allows the identification in improvements to NHS 24’s systems and processes.
• is a useful tool to identify trends and risk factors which create the conditions in which incidents occur.”

2.1.10 NHS 24 has undertaken an internal review of its adverse event management process. It initiated the review in response to the NHS Ayrshire & Arran report findings, and to identify requirements for a new electronic system to manage adverse events. The new system, iCaseworks, will capture all information and documentation on adverse events, complaints and partner feedback within a single database. It will replace the existing system ‘RESPOND’. The new system forms part of a significant service redesign programme of work, called the ‘future programme’.

2.1.11 At the time of the visit, NHS 24 was finalising the development of the new system and had introduced training for staff in advance of implementation.

Governance arrangements

2.1.12 NHS 24 has a national patient safety group which monitors adverse events and reports into the national clinical governance group. The national clinical governance group is responsible for overseeing clinical governance, including patient safety, across the
organisation. It reports into the clinical governance committee which in turn reports into the Board. At service level, adverse incidents are monitored through regional and operational clinical governance groups.

2.1.13 Figure 1 below outlines the clinical governance structure for managing adverse events.

**Figure 1: NHS 24’s clinical governance structure**
3 Detailed review findings

3.1 Engaging with stakeholders

NHS boards should ensure that they are taking an active and planned approach to engaging with key stakeholders, particularly the patients, family and carers affected by a significant adverse event.

Partner involvement

3.1.1 NHS 24 has contact with many external partner organisations. For example, GPs, in-hours primary health care, out-of-hours services, the Scottish Ambulance Service, accident and emergency, falls services, minor injury units, mental health services, other healthcare professions, and the police. NHS 24 informed us that it does not routinely receive information on patient outcomes from partner organisations. This can limit its engagement with patients and family and the identification and learning from near miss events. When patient safety incidents are identified through feedback from partner organisations, it is not always appropriate for NHS 24 to contact the patient or family.

3.1.2 NHS 24 usually has only brief contact with the patient while partner agencies are involved in the remainder of the patient journey. NHS 24 often has to rely on partner agencies to provide feedback on adverse events to help it investigate issues, identify learning and help prevent them happening again. NHS 24 informed us that it encourages partner engagement and feedback through regular meetings and through an agreed single point of contact within NHS 24. It uses an electronic partner feedback mailbox as a central repository for all partner correspondence. This supports timely review of issues raised and the identification of themes.

3.1.3 Staff informed us that a process is in place for managing requests for information from the police, solicitors or the Procurator Fiscal. Staff are required to complete an adverse incident report form for any such requests which involve NHS 24, or which relate to the investigation of crime. In such instances, NHS 24 undertakes a clinical review of the initial patient call to identify potential organisational learning and to assess whether an appropriate outcome of care had been reached.

Patient, family and carers involvement

3.1.4 The policy states:

“NHS 24 recognises that there is a need to share information regarding Patient Safety Incidents with patients and their families and to this end advocates that the disclosure to the patient and/or their families should be considered for all Patient Safety Incidents.

- Information should be disclosed to the patients unless the lead professional responsible for care believes that disclosure of the incident would not be in the “best interest of the patient” i.e. have a harmful effect on the physical or mental health of the patient.
- It is natural for those involved in treatment or advice which produces an adverse result to sympathise with the patient or the patient’s relatives and to express sorrow or regret at the outcome. A full and frank explanation of what has occurred must be shared with the patient as soon as is practical. There should be a factual statement
of what happened with a clear statement of regret for any distress. Information regarding the process for investigation should also be shared.

- This explanation to patient and/or their family who have been harmed as a result of their healthcare treatment is not an admission of liability but it does acknowledge that an incident has taken place together with regret for what has happened, and it is very important for the patient and/or their family to have this acknowledgement.

- The Patient and/or their family must have access to a named single point of contact within the organisation who will liaise with them to ensure clear channels of communication are in place so that they can speak to that person again if they wish clarification or further information.

- Where appropriate there should be a meeting arranged with the patient and their family and for this meeting to be clarified in writing with the points discussed and follow up meetings arranged at this time if it is felt pertinent, to the situation.”

3.1.5 The policy also states that: “Incidents cannot be disclosed to the next of kin, carer, GP or media etc. without the patient’s consent.”

3.1.6 NHS 24 has a unique service in that all contact by patients, their family or carers is recorded and call records are kept as part of the audit process. Patients, families and carers are able to request a copy of their contact through the access to health records process. This supports a transparent approach and a fact-based investigation process when adverse events are identified.

3.1.7 We analysed documentation provided for the four cases selected for detailed review. Only one of the cases had evidence of engagement with the patient or family beyond the initial call(s) to NHS 24. In this case, the adverse event arose following a letter of complaint from the family to NHS 24. The evidence included correspondence letters and references to meetings held with the family. The family was made aware of the key findings and learning points following the investigation, but were not offered a copy of the investigation report. There was no evidence to show the family being invited to take part in the investigation or having input to the development of an action plan.

3.1.8 The other three cases had no evidence of engagement with the patient or family beyond the initial call(s). In one of these cases, staff informed us that they would have been happy to contact the patient or family. However, the case arose through partner feedback and the partner NHS board advised that contact would have been inappropriate under the circumstances. We saw evidence of NHS 24 contacting the partner NHS board to ask after the welfare of the patient and to seek further background information on the incident.

3.1.9 Another of these cases originated through partner feedback and we saw evidence of the final report being shared with the GP. However, NHS 24 staff did not know whether the GP shared the final report with the family.

3.1.10 The fourth case was identified following police contact with the service. At the time, NHS 24 did not consider it appropriate to contact the family given the police involvement. NHS 24 was not aware of the level of contact the police had with the family.
3.1.11 On the visit, staff told that they would usually offer the family a copy of the final report. However, NHS 24 would not normally involve the family in the investigation or action plan development. The family would usually be told about the key learning points and outcomes resulting from the investigation through a formal response letter.

3.1.12 NHS 24 recognises a challenge in not knowing the outcomes of patient contact with the service. At the time of the visit, NHS 24 was discussing with NHS National Services Scotland how it might capture data on final patient outcomes through feedback from NHS boards.

3.1.13 NHS 24 informed us that it has been moving towards greater openness in sharing information and outcomes arising from the investigation process. At the time of the visit, NHS 24 was reviewing how it engages with patients, family and carers.

3.1.14 On 18 September 2013, a paper on the management of adverse event reviews was discussed at the clinical governance committee. The paper identified NHS 24’s current position against the NHS Ayrshire & Arran review recommendations and outlined proposals for change or action. The paper suggests adding being open guidance to the policy, based on the National Patient Safety Agency guidance: Being Open: Communicating Patient Safety Incidents with Patients and their Carers (2009).

Staff involvement

3.1.15 In July 2010, NHS 24 introduced a rolling programme of patient safety leadership walkrounds to allow staff across the organisation to highlight issues to senior managers. Staff are selected at random to take part in the walkrounds. We saw evidence of the patient safety leadership walkround action plan. This is used to record actions arising from the walkrounds, action owners, progress and target timescales for updates. We also saw evidence of the action plan being discussed at the clinical governance committee. We noted the benefit of these walkrounds in providing staff with an opportunity to raise issues that concern them.

3.1.16 NHS 24 reported that it focuses on learning as an organisation and not on individual blame. However, the nature of its service means that staff are a key part of any investigation process. Staff work independently, but closely supported by a framework of clinical and operational supervisors and decision support materials. All contacts with the service are recorded and an electronic record is kept of all decisions taken by staff to reach a particular outcome. When a potential adverse event happens, the staff member involved and their line manager review the original call in a dedicated listening room.

3.1.17 The policy notes the distinction between the adverse event investigation and the disciplinary process:

“The focus of the investigation being undertaken following a patient safety incident is not to apportion blame but to improve systems and practice. Patient safety incident investigations are not part of the disciplinary process.”

3.1.18 Staff we spoke with, who had been involved in the adverse event process, felt there was an open and positive culture within NHS 24 with a focus on improvement and change. However, some frontline staff informed us that the adverse event process could feel negative for them, particularly when there was negative reporting in the media. However, all staff we spoke with felt there is a positive culture for reporting adverse events across NHS 24.
The policy states:

“NHS 24 acknowledges that staff involved in a Patient Safety Incident may be distressed and their wellbeing should be considered at all times during the investigation process. Each individual member of staff must have access to a named single point of contact within the organisation who will liaise and ensure clear channels of communication are in place for all matters relating to the investigation process. This single point of contact may be their line manager but this can be mutually agreed by the line manager and the member of staff. Staff should be supported by the organisation. This can vary from support by their line manager to a “buddy” – a person to whom the member of staff can talk to or relate to. The method of support will be agreed between the staff member and their line manager. Staff should be made aware at the start and throughout the investigation process that counselling services can be offered through NHS 24’s support organisations which are detailed within the Intranet.”

On the visit, staff informed us that team leaders would normally tell staff about a potential adverse event that involved them, before they started their next shift.

The policy states:

“The Lead Manager must ensure that the staff member(s) involved in the incident has received the relevant level of support; this may involve professional/non professional counselling for example access to confidential counselling services offered by NHS 24 alternatively the staff member can self refer to Occupational Health.”

We saw evidence of team leaders providing information about the employee assistance programme and offering counselling to staff within the one-to-one discussions.

NHS 24 informed us that it has coaching teams within all four regional contact centres. These teams support and coach staff following the identification of an adverse event. If staff are taken off patient calls following an adverse event, they remain within a coaching environment to support their return to patient contact.

On the visit, staff told us that they generally felt supported following an adverse event and knew who to approach if they needed help. However, some staff informed us that while they were aware of support options, they sometimes had to seek out support themselves.

The policy includes comprehensive guidance for managers on how to undertake staff interviews following the identification of an adverse event. This includes guidance on the format of the interview, types of questions to ask and how to record the discussion. Staff interviews are also known as one-to-one interviews:

“The initial 121 with the staff involved in the incident should be undertaken at the first opportunity, this discussion with staff should include as much information as possible on the Patient Safety Incident being provided to the staff involved, discussion on the call review and the outcome of the fitness to practice assessment. Following this meeting the Team Leader/CSM should
notify the Investigation Team of any key issues identified, actions taken and training information.”

3.1.26 A template form is available for managers to record the one-to-one discussions with staff:

“This form will be used to record informal review meetings between Line Managers/Team Leaders and individual team members in NHS24. This form is intentionally unstructured to allow it to be used for virtually any kind of meeting. Please record the discussion and the outputs from the meeting and file this document in the agreed place.”

3.1.27 The evidence provided for the four cases confirmed that a call review had been done in each case. All four cases also had evidence of documented one-to-one meetings between the staff member involved and their team leader using the standard template. We noted that the template includes a question to ask staff if there were any influencing factors which might have had an impact on how they handled the call. However, the form does not directly ask staff whether there are any issues which they would like the investigation team to look into as part of the investigation.

3.1.28 The policy states:

“Feedback should always be provided directly to the individuals involved in the incident, in advance of briefings being shared across the organisation. The Regional/Service Clinical Governance Group will achieve this through the relevant Team Leader/Line Manager. It is vital that the confidentiality of the staff involved in the incident is maintained.”

3.1.29 Our discussions with staff revealed that feedback was not consistently provided to them following an adverse event. Frontline staff told us that they did not always receive feedback and sometimes had to chase up a response to find out the outcome of a review or investigation.

3.1.30 The policy states that the final investigation report should be shared with the staff involved to provide them with the opportunity to reflect and comment on the findings.

3.1.31 None of the cases had evidence of the investigation report being shared with frontline staff involved to allow them to comment on the findings. In two of the cases we reviewed, frontline staff had been given a copy of the final report for their information. In one case, staff confirmed that they were not given a copy of the final report. In the fourth case, there was no evidence to confirm whether staff received the final report.

3.1.32 NHS 24 informed us that a copy of the investigation report would normally be offered to staff, but this was not done in every case.

3.1.33 On the visit, frontline staff told us that they are not involved in patient safety incident investigations and have no input into identifying improvements or developing the action plan. We noted that NHS 24 would benefit from involving frontline staff in considering issues for investigation and in identifying solutions following an adverse event.

3.1.34 NHS 24 informed us that it undertakes exit interviews with all staff who leave the organisation. This helps identify areas for improvement. NHS 24 has also carried out a
survey of staff known to have been involved in an adverse event investigation. The survey results revealed a broad range of experiences and identified recommendations, including the need to standardise support provided to staff.

**Recommendations**

NHS 24’s active and planned approach to engaging with key stakeholders, particularly the patients, family and carers affected by a significant adverse event, should:

1. always consider involving patients and family in the investigation process. If involvement does not take place, NHS 24 should record the rationale for not doing so
2. introduce a process to demonstrate that staff are actively involved throughout the investigation process, including identifying issues for consideration, and they receive appropriate feedback and updates on progress and outcomes, and
3. ensure staff involved in a patient safety incident receive a copy of the investigation report for comment and have input into the development of the action plan, where appropriate.

### 3.2 Staff knowledge and training

NHS boards should ensure that their staff are trained and have suitable knowledge and understanding to be involved and contribute to the full management of significant adverse events including the implementation of actions relating to learning, change and improvement.

**3.2.1** NHS 24 reported that all operational staff receive information on adverse event management at induction through a clinical governance module. The module includes guidance on how to report adverse events and the roles and responsibilities of individuals within that process.

**3.2.2** All staff are required to undertake a mandatory e-training module on risk management. NHS 24 also has six mandatory clinical e-learning modules:

- adult support and protection
- child protection
- chest pain
- meningitis
- recognition of the acutely ill adult, and
- recognition of the acutely ill child.

**3.2.3** Staff are required to keep their e-learning up to date and team leaders are responsible for making sure this happens.

**3.2.4** The policy refers to the need to identify staff training needs to ensure staff receive effective training. The policy does not list the training courses available to staff to support them in the adverse event management process.

**3.2.5** NHS 24 reported that all staff are trained on how to complete an adverse incident report form. Staff usually complete a hard copy of the form and their line manager...
arranges for it to be added to the RESPOND system. NHS 24 confirmed that frontline staff do not use RESPOND.

3.2.6 NHS 24 has a clinical education and practice development group which meets every 3 months. The group reviews and approves all clinical educational modules, materials and resources used in the induction programme or clinical professional development. The group works to ensure consistency in the design of educational materials and to promote evaluation of resources and materials that support clinical practice. NHS 24 reported that it regularly reviews all clinical governance training materials in response to evaluation and feedback.

3.2.7 We noted that an update from clinical education practice development is a standing agenda item at the national clinical governance group meetings. Staff training is also discussed at the national patient safety group.

3.2.8 In all four cases we reviewed, the line manager met with staff involved to review the adverse event. This included an assessment of staff knowledge and any requirements for coaching or further training. Two of the cases had evidence of a coaching and personal development plan in place for staff involved. The other two cases had reference to a personal development plan being initiated or completed. However, the development plans were not provided as evidence.

3.2.9 We noted the one-to-one sessions are a useful way for managers to identify staff training needs and to get feedback on training received.

3.2.10 NHS 24 informed us that clinical governance and quality leads deliver a detailed clinical governance and risk management session to managers. The session forms part of the manager foundation programme. In 2006–07, a session focusing on investigation skills was delivered to a multidisciplinary group of staff.

3.2.11 The policy states that at least one member of the investigation team should be fully trained in how to undertake root cause analysis. Our discussions with staff revealed that at least one member of each investigation team had received training in root cause analysis. This included clinical service managers, senior managers or clinical governance and quality leads. However, we noted that a number of staff had attended the training several years ago. Some staff informed us that they would welcome refresher training.

3.2.12 NHS 24 acknowledges that its regional centres currently have varying approaches, resources and staff skills for undertaking adverse event investigations. This includes variation in the investigator’s role. At the time of the visit, NHS 24 was considering options for training a core group of investigators to ensure consistency across the organisation.

NHS 24 informed us that training and support for staff is being delivered as part of implementing the future programme.

**Recommendation**

To support staff knowledge and training, NHS 24 should:

4 provide up-to-date investigation training or refresher courses for key staff involved in investigations to ensure a consistent approach when reviewing adverse events.
3.3 Roles and responsibilities

NHS boards should ensure that all members of staff have a clear understanding of their roles and responsibilities regarding significant adverse events and that clear lines of accountability are defined and reflective of the organisation's governance structure.

3.3.1 The policy documents the roles of the various governance committees relating to the management of adverse events. The policy also documents the roles of different teams within the adverse events management process.

Governance groups

3.3.2 The clinical governance committee provides assurance to the Board that appropriate clinical governance mechanisms are in place throughout the organisation. The committee meets every 3 months.

3.3.3 A national clinical governance group meets every 3 months. The group scrutinises clinical governance activity across NHS 24 to assure the clinical governance committee that effective clinical governance is in place. It consists of representatives from the regional clinical governance groups and senior managers from across the organisation. The group reviews regional centre reports under the guidance of the head of clinical governance, quality and patient safety. It also identifies trends arising from local reviews and produces action plans to mitigate any potential service-wide risks. The group is required to inform the clinical governance committee of any identified trends and corrective actions taken.

3.3.4 The regional or service clinical governance groups meet each month to monitor clinical governance across the contact centres. These groups provide assurance to the national clinical governance group. NHS 24 informed us that it actively encourages frontline staff, including call handlers and nurse advisors, to attend these meetings.

3.3.5 A national clinical effectiveness group meets every month to review and co-ordinate clinical effectiveness activity across NHS 24. It provides assurance that the clinical effectiveness work plans are implemented appropriately.

3.3.6 NHS 24 has a national patient safety group which meets at least once a month and reports into the national clinical governance group. The nurse director, who is accountable for patient safety and clinical governance, chairs the meetings and is required to escalate issues or risks as required. The group includes representatives from the clinical directorates. Weekly meetings are arranged when required to support the patient safety incident reporting process.

3.3.7 The core purpose of the national patient safety group is to:

“Ensure a focus on system-based problem solving which will enable us to break the link in the chain of events that can create a recurring problem ensuring, that the organisation learns from experience including near misses which occur at a much higher frequency than actual events. The National Patient Safety Group should ensure the organisation can demonstrate improvement as a result of learning, while enabling the reduction and prevention of harm to our patients as a result of their care.”

NHS 24 has a series of specific governance groups to support clinical effectiveness, including:

- a core clinical group (meets every two months)
- child protection action group (meets every 6 weeks)
- clinical and operational process review group (meets every month)
- call review steering group (meets every two months)
- area partnership forum (meets each month)
- business continuity management steering group (meets every month)
- health content governance group (meets every month)
- clinical advisory group (meets every 3 weeks), and
- dental advisory group (meets every 3 weeks).

A clinical governance public panel meets every 3 months to allow members of the public to participate in clinical governance activity. NHS 24 also has a group of public partners who attend the national clinical governance group, regional clinical governance groups and national patient safety group meetings.

Investigation Team

The investigation team usually includes the lead clinical services manager, associate director of operations and nursing, associate medical director, a member of the clinical development team, and the clinical governance and quality lead. Specific specialties are included in the team where required, for instance, learning and development or mental health colleagues. NHS 24 informed us that staff from other regions can be asked to join the investigation team if additional skills are required.

The clinical governance and quality lead co-ordinates the investigation. This includes notifying relevant people, arranging meetings, sending the validation form for approval and setting up a secure folder on a shared drive to capture relevant documentation. The lead also sends reminders to managers when actions arising from the investigation are due for completion.

The clinical development team reviews patient safety incidents concerning the use of clinical decision support tools. For example, algorithms, call streaming and call handler protocols. The clinical development team provides an objective overview of any required changes to the clinical content, or expertise on how the system could be used more effectively.

Governance reporting

NHS 24 reported that outcomes of investigations and recommendations are presented to the national patient safety group for detailed discussion and approval. Actions identified for local learning or performance management issues are progressed through regional structures. Organisational learning actions are monitored as a standing agenda item at the regional clinical governance groups. Elements of organisational learning are considered for inclusion within the annual clinical audit operational plan.
3.3.14 We saw evidence of clinical governance committee, national clinical governance group and national patient safety group meeting minutes covering the last 18 months.

3.3.15 A national patient safety and performance report is compiled every 3 months to:

“Provide the Clinical Governance Committee with assurance that the organisation is learning and actively seeking and implementing organisational actions to address issues and themes identified within the National Quarterly Patient Safety and Performance Report.”

3.3.16 The report is discussed and approved at the national patient safety group before going to the clinical governance committee for discussion. The report is also presented to the national clinical governance group for discussion and at the regional clinical governance groups for information.

3.3.17 We saw evidence of the report being discussed at governance meetings. At the time of the visit, NHS 24 had renamed the report as the ‘healthcare quality report’.

3.3.18 The patient safety leadership walkround action plan is also a standing agenda item at the national clinical governance group meetings.

3.3.19 Our review of documentation revealed that all four cases were discussed at both a regional clinical governance meeting and at the national patient safety group. This was evidenced by formal meeting minutes.

Roles and responsibilities

3.3.20 The policy lists the responsibilities of different roles within the adverse event management process. This includes the:

- chief executive
- nurse director
- medical director
- head of clinical governance, quality and patient safety
- clinical services manager or service manager
- team leader or line manager
- clinical governance and quality lead
- associate director of operations and nursing
- clinical development team
- service support manager, and
- person completing the adverse incident report form.

3.3.21 The policy states that the chief executive is accountable for clinical governance within NHS 24. This includes responsibility for reporting performance data on accidents, adverse incidents and occupational ill-health to the Board. The chief executive devolves accountability for clinical governance to the medical and nurse directors.
On the visit, the chief executive confirmed that he attends all Board and clinical governance meetings where possible. He regularly reviews adverse incidents, complaints and partner feedback through executive team meetings, clinical governance committees and Board meetings. He is also made aware of all patient safety incidents which arise within the organisation and is regularly involved in the adverse event management process.

While the policy sets out expectations of staff and leadership roles, it does not include explicit reference to Board accountability.

The policy states that all staff:

“Have a responsibility to report any Patient Safety Incident/near miss to their immediate manager, whether they were directly involved, or which they witnessed.

“Must act in compliance with this policy and other related NHS 24 Organisational Policies and Procedures e.g. Confidentiality Policy, Complaints Policy, Procedure for Handling Media Enquiries, Crisis Media Plan.

“Must take individual responsibility to benefit from the learning created by Patient Safety Incident Management and to undertake any relevant personal development as a result.”

NHS 24 reported that staff receive instruction on roles and responsibilities at induction.

On the visit, our discussions with staff confirmed that staff involved in the adverse event management process are aware of their roles and responsibilities.

**3.4 Information management**

NHS boards should ensure that their document control and related information systems are suitably integrated and robust to provide a complete audit trail of significant adverse event management from the incident occurring to evidencing change and improvement. These systems should also allow NHS boards to undertake ongoing thematic learning from significant adverse events.

NHS 24 currently uses the electronic system RESPOND to capture information on adverse events. The system records information on adverse events, partner feedback, complaints, freedom of information requests, risk and requests for access to health records. Staff have pre-determined access privileges which determine what information they can view on the system.

The RESPOND system does not allow automatic notification to relevant staff when an adverse event is recorded. Although the system helps staff to compile the content of the email, staff still have to physically send it. However, the system contains a useful link to the patient safety incident validation form and allows staff to link to the email system to send the completed form for approval. These activities are recorded as part of the audit trail.
3.4.3 Staff can also record actions arising from patient safety incidents. The information can then be extracted into an Excel spreadsheet. However, the system does not trigger automatic reminders for when particular actions are due for completion.

3.4.4 The system allows staff to interrogate the information on RESPOND to identify adverse event themes.

3.4.5 Staff can use RESPOND to link emails and documentation relating to patient safety incidents. Staff also use a separate network location to store all documentation relating to investigations. This includes draft and final versions of investigation reports. The NHS board reported that this location is appropriately controlled and only accessible by staff with access privileges.

3.4.6 The policy states:

“Folders with all relevant details associated with the incidents are held within the R: Drive/PSI working folders and within the Patient Safety Incident Database. This documentation will include as mandatory:

- Clinical Investigation Report (i.e. complaints, partner feedback or AIR investigations)
- AIMS Validation Form
- 10 Day Report
- 30 Day Report
- Supplementary documentation or reports

“Due to the sensitive nature of the contents of these folders access is restricted to Lead Investigators, Lead Manager, Associate Medical Director, Associate Director of Operations and Nursing and Clinical Governance & Quality Team...in all instances. Incidents cannot be disclosed to the next of kin, carer, GP or media etc. without the patient’s consent.”

3.4.7 One of the four cases we reviewed had evidence of a folder on a shared drive where copies of correspondence, communications and draft reports were stored together. This case also referred to correspondence and communications being added to RESPOND. The other three cases had no evidence to confirm whether accompanying documents were uploaded to a central location. Staff on the visit told us that documentation relating to a patient safety incident is normally stored within a central folder on a shared drive.

3.4.8 NHS 24 has an adverse incident report form for recording adverse events. NHS 24 confirmed that it does not generate an adverse incident report form for incidents which arise, either through partner feedback or the complaints process. However, such incidents would enter the same investigation and validation process as incidents originating from an adverse incident report form.

3.4.9 NHS 24 informed us that the patient safety incident report template is automatically populated with relevant information recorded on RESPOND. This reduces the time that staff have to spend in compiling the report.
3.4.10 At the time of the visit, NHS 24 was developing a new electronic system, iCaseworks, to replace RESPOND. The new system is a made-to-order database for managing all information and documentation relating to adverse events, complaints and partner feedback. It will deliver a fully integrated reporting solution which will allow all staff to report incidents electronically. Once the system is implemented, the paper-based adverse incident report form will no longer be required.

3.4.11 The new system will be able to capture relevant documentation, including staff one-to-one interviews, and track escalation of adverse events and completion of actions. NHS 24 anticipates that iCaseworks will be able to send automatic notifications to relevant staff when an adverse event is recorded on the system. The new system will also automatically flag up the caller history on the screen to identify return callers.

3.4.12 Our review of the four cases showed good use of version control in all clinical investigation reports, patient safety incident validation forms and patient safety incident reporting forms. However, in all four cases, the clinical development team review document was in draft form and only mentioned the month and year it was compiled.

**Thematic learning**

3.4.13 NHS 24 informed us that themes for organisation learning are identified from multiple sources. These include feedback from external partners, complaints, compliments, comments, performance management data, adverse events and risks identified through monitoring systems.

3.4.14 The policy states that:

“Emerging themes from Patient Safety Incidents, complaints and partner feedback will be reported to the National Patient Safety Group through the Patient Safety Report, this group will identify the most appropriate actions to support organisational learning.”

3.4.15 The national patient safety and performance report is compiled every 3 months. It is provided to the national patient safety group, national clinical governance group and the clinical governance committee. It includes the following as standing agenda items:

- trend analysis
- strategic priorities or adverse incidents report forms
- patient safety incidents
- vulnerable children, young people and adults
- patient safety leadership walkrounds
- call consultation review
- patient feedback - complaints, concerns and compliments
- partner feedback, and
- generic themes and trends - clinical condition, assessment, systems or procedural.

3.4.16 The report provides data on the number of comments, complaints, compliments, concerns and enquiries received from patients. It includes data on the number of adverse incident report forms and patient safety incidents by category, with summary
comments on particular issues. The report states that: “All organisation learning and recommendations resulting from the root cause investigation of Patient Safety Incidents (PSI) have been collated in their related themes.”

3.4.17 The report includes a section on organisational and individual learning which highlights learning and resulting actions. The report shows the themes identified from all incidents recorded on RESPOND. It also lists the hot topic bulletins issued to staff and provides an update on key themes identified through the patient safety leadership walkrounds.

3.4.18 We saw evidence of the report being reviewed and discussed at governance meetings. The minutes of the March 2013 clinical governance committee recorded:

“The Committee noted the report, welcoming the assurance it provided, and asked that text size be reviewed with a view to improving legibility and ensuring a standard ‘look and feel’ across the report.”

3.4.19 We saw evidence of the results from the patient experience survey being discussed at the national clinical governance group and the clinical governance committee. We also saw evidence of regular meetings between NHS 24 and its partner NHS boards which included discussions relating to adverse events.

3.4.20 NHS 24 reported that it presents a number of key performance indicators from its local delivery plan and corporate plan to the Board, executive team and other committees.

3.4.21 Our review of the four cases revealed examples of improvements made in response to adverse incidents, including changes to guidance and training materials.

Recommendation
To support its information management processes, NHS 24 should:

5 introduce a process to demonstrate that all documentation relating to a patient safety incident is stored in a secure central location with evidence of final version control.

3.5 Risk-based, informed and transparent decision-making

NHS boards should ensure that the decisions related to the management of significant adverse events are risk based, informed and transparent to allow appropriate level of scrutiny and assurance.

Identification, notification and initial event reporting

3.5.1 NHS 24 identifies potential adverse events which may require an investigation through a number of internal or external sources. Sources include GPs, out-of-hours services, the Scottish Ambulance Service or NHS board clinicians. Adverse events can also be identified through complaints, comments, police contact or public media.

3.5.2 NHS 24 uses a standard risk matrix to grade potential adverse events. The policy includes guidance for staff on what to consider when grading a patient safety incident. The patient safety incident report template also includes the risk matrix charts and definitions to help staff determine risk grading. We identified this as good practice. On the visit, staff confirmed that they were comfortable using the risk matrix.
**Escalation of events**

3.5.3 NHS 24 has an escalation structure which allows the clinical investigator to escalate a potential adverse event which may require further assessment or full investigation. The structure includes senior medical and nursing staff.

3.5.4 Incidents graded as extreme, major or moderate are escalated for investigation through the patient safety incident validation process. The draft risk grading is generally agreed within the investigation team and forwarded to a senior manager for approval. Incidents graded as major or extreme are ultimately approved by the national patient safety group. Incidents which result in the death of a patient, including deaths which indirectly involved NHS 24, must be presented to the national patient safety group for review. This is regardless of the risk grading.

3.5.5 Incidents which are defined as negligible or minor are not escalated for patient safety investigation. NHS 24 reported that the team leader would usually share the learning from these incidents with staff or take forward quality improvements.

3.5.6 NHS 24 has a validation form for staff to record the incident situation, background, assessment and recommendation. Staff are required to use the form to seek formal approval to progress an incident through the patient safety incident process.

3.5.7 The policy states:

“*When a Patient Safety Incident is identified the Lead Manager will discuss the event with the Associate Director of Operations & Nursing (ADON)/Service Manager or Associate Medical Director (AMD) who will review the call(s) and approve the incident as a Patient Safety Incident.*

“*On identification of a potential Patient Safety Incident the Lead Manager should notify the Clinical Governance & Quality Lead who will update the Patient Safety Incident Database, and issue the incident Validation Form for approval, after all parties have listened to the calls a decision is made on the escalation of the incident.*

“*The Associate Director of Operations & Nursing /Associate Medical Director (or delegate) documents their decision to escalation to a Patient Safety Incident and forwards confirmation of this to the Clinical Governance, Quality and Patient Safety Support Unit.*

“*The Clinical Governance, Quality and Patient Safety Support Unit will update the Patient Safety Incident database (Respond). If the Incident has been validated as a Patient Safety Incident the Clinical Governance & Quality Lead will send out via email the appropriate notification to the organisation.*

“*On receipt of the validation the Clinical Governance & Quality Lead should record within Respond and issue organisational/regional notification.*”
3.5.8 NHS 24 informed us that the clinical governance and quality lead normally circulates notifications of patient safety incidents the same day they are validated. Notifications are usually sent to the following:

- nurse director
- medical director
- director of unscheduled care
- associate directors of operations and nursing or general manager
- associate medical director
- associate director of nursing and clinical governance
- clinical development team
- clinical service managers
- clinical governance and quality team, and
- regional or service team leaders.

3.5.9 The policy states:

“The Associate Director of Operations and Nursing should provide a rationale for any Potential Patient Safety Incident that is not escalated to a full Patient Safety Incident Investigation. This rationale for the decision not to escalate should be recorded within the Patient Safety Incident Database along with any supporting evidence.”

3.5.10 On the visit, staff told us that they would record reasons behind any decision not to proceed through the patient safety incident process. NHS 24 informed us that the new iCaseworks system will include a mandatory field to record the rationale for decision-making and the level at which the decision was made.

3.5.11 We saw evidence of the clinical risk register being discussed at the clinical governance committee and national clinical governance committee as a standing agenda item.

3.5.12 All four cases we reviewed had evidence of a completed validation form to formally validate the incident as a patient safety incident. All four cases also had evidence of the incident being notified or escalated to relevant members of staff.

**Investigations**

3.5.13 NHS 24 gathers evidence from the recordings of contact made with the service to help inform adverse event investigations. NHS 24 informed us that it undertakes a multidisciplinary approach to reviewing investigation outcomes and recommendations. The clinical development team undertakes an in-depth review where algorithm use is identified as a factor, to make sure that all aspects of the algorithm are relevant and effective.

3.5.14 The policy contains comprehensive guidance on how to carry out investigations:

“To allow the Investigation Team to explore or further understand the issues identified within the Patient Safety Incident Case reviews should be considered as part of the initial investigation meeting. The Investigation Team should
identify the area(s) being explored as part of the analysis and identify the criteria for case selection (i.e. chest pain), and the number of records being reviewed (suggested 5 minimum, 10 maximum) The Case reviews should be undertaken utilising the Patient Call/Consultation Review Matrixes. This activity should be captured on the Team Meeting Action plan with agreed timescales, the findings of the case reviews should be reported to the Investigation Team Meeting.”

3.5.15 NHS 24 has a patient safety incident report template which is laid out in SBAR (situation, background, assessment and recommendation) format. The policy includes guidance on the timescales for producing the report, what should be included and who should approve it:

“The production of a report provides a formal framework for incident management, but this should be a dynamic process. This is about practical management of the incident and not simply a paper exercise. All Patient Safety Incidents should be reported on the Patient Safety Incident Report Template.

“The final report should be reviewed and approved by the investigation team including the Associate Director of Operations & Nursing prior to its submission to the National Patient Safety Group or service/regional clinical governance group. Reports should be sent to the Clinical Governance, Quality and Patient Safety Support Unit by the Thursday before the Tuesday meeting which the report is scheduled for presentation.”

3.5.16 NHS 24 recently introduced a patient safety incident report flow chart (dated 16 September 2013) outlining the process for submitting investigation reports for approval. The flow chart includes guidance on staff roles involved in validation, investigation, decision support review, and report approval.

3.5.17 The policy has detailed guidance on how to carry out root cause analysis. It outlines investigation tools which staff could use, such as the five whys tool or the fishbone diagram.

3.5.18 All four cases we reviewed had evidence of a clinical development team review, a formal investigation and a completed patient safety incident report. None of the cases had documented evidence of specific root cause analysis tools being used as part of the investigation. On the visit, staff confirmed that they used investigation methodologies including human factors or 5 whys analysis.

3.5.19 Three of the cases had reference to reviews of supporting materials or procedures. This included reviews of learning materials, clinical decision support, induction programme or performance management.

3.5.20 At the time of the visit, NHS 24 was reviewing how it undertakes investigations. It was planning to establish a more formal and consistent investigation process. This includes consistent feedback to staff, quality assuring outcomes and establishing a core group of investigators who are appropriately trained to carry out investigations. The new process would ensure patient safety incident reviews are undertaken consistently whether they arise through partner feedback, complaint or potential adverse event.
Multiagency investigations

3.5.21 The policy states that:

“Patient Safety Incidents may involve other partner organisations across the patient journey. Therefore joint investigations into incidents should be encouraged as we continue to work closely with partners on the clinical governance agenda.”

3.5.22 The policy includes guidance on involving partner NHS boards in investigations:

“A single point of contact should be agreed for each board who would act as coordinator for the NHS Board’s service input and/or dissemination of information. Where appropriate the NHS Board will be notified of all Patient Safety Incidents (Major/Extreme or Moderate) raised by NHS 24 regarding patients in their area. The NHS Board’s single point of contact should be invited to take part in investigations for patients in their NHS Board area including circumstances where the incident is NHS 24 specific. In circumstances where there are multiple agencies involved in the incident, the contact (or nominated deputy) shall participate in investigations.”

3.5.23 The policy also includes a flow chart outlining the process for involving partner organisations. The flow chart guides staff to forward the final 30-day report to the partner organisation on completion.

3.5.24 Two out of the four cases we reviewed originated through feedback from partner organisations. Both of these cases had evidence of notifications or updates provided to the partner organisation.

Recommendation
To support a risk-based, informed and transparent approach, NHS 24 should:

6 continue to implement plans to standardise the investigation function to ensure a consistent process for investigating patient safety incidents, whether they arise through partner feedback, complaints or potential adverse events.

3.6 Timely management, learning, dissemination and implementation

NHS boards should ensure that the management of significant adverse events is completed in a timely manner and that the thematic learning is appropriately disseminated and acted upon throughout the organisation.

Investigation and reporting timelines
3.6.1 The policy states that an initial investigation report should be completed within 10 days:

“Initial Report (10 day): This investigation should be utilised to populate the summary of event within the 10 day report for the Patient Safety Incident. The information within this report should form part of the Patient Safety Investigation Template. An initial report will be expected within 10 days, and should include Membership of the investigation team; Patient Details; Case details; Statement of event (including timeline) and Issues identified for review.
“A final report will be expected within 30 days for all incidents.”

3.6.2 The policy does not specify at what point the 10 and 30-day deadlines commence and whether the timescales are calendar or working days.

3.6.3 NHS 24 confirmed that the initial report is expected within 10 working days of the incident being validated as a patient safety incident, and the final report is expected within 30 working days of validation.

3.6.4 Only one out of the four cases had evidence of the initial investigation being completed within 10 working days of the incident being validated as a patient safety incident. None of the cases met the policy deadline for completing the final investigation report within 30 working days of validation.

3.6.5 The policy has a deadline for informing staff who are involved in an incident:

“On validation of a Patient Safety Incident the Lead Manager should ensure that all staff member(s) involved in the incident are informed of the investigation where possible within 3 days.”

3.6.6 Two out of the four cases had evidence to confirm that staff members involved were notified of the investigation within 3 days of validation. The other two cases did not have any evidence to demonstrate whether staff were notified within this timescale.

3.6.7 NHS 24 acknowledges that meeting investigation timescales can be challenging, particularly when part-time staff are involved. It acknowledges that it could improve the monitoring of investigation timescales.

**Action planning**

3.6.8 The national patient safety group is required to monitor implementation and closure of actions each month for reporting to the national clinical governance group.

3.6.9 Three out of the four cases had evidence of a formal action plan or log to record actions, owners and target dates for completion, following a patient safety incident. In the fourth case, we saw evidence of actions captured in the report and in the patient safety incident meeting minutes. This included identified owners and target completion dates.

3.6.10 NHS 24 provided good evidence to demonstrate that managers follow up on action points and maintain records to demonstrate the completion of actions. In all four cases, we saw evidence of emails from the clinical services manager or clinical governance and quality lead to check progress of actions to make sure actions were completed.

3.6.11 One of the cases had evidence of an Excel spreadsheet used by the north region to track actions arising from patient safety incidents. This included relevant team meeting and governance meeting dates and the final status of actions across the region. NHS 24 informed us that each of the regions uses a spreadsheet to track actions and recommendations.

3.6.12 NHS 24 informed us of plans to work with regional representatives and quality leads to standardise the approach to tracking actions and recommendations. NHS 24 recently combined the regional spreadsheets to form a national spreadsheet. This will allow it to
monitor the progress of actions and recommendations across the organisation. NHS 24 also intends to introduce a standing agenda item at the national patient safety group meetings, to monitor the implementation of outstanding actions.

Sharing of learning

3.6.13 The terms of reference of the national patient safety group include the following responsibilities:

- “National Patient Safety Group to receive all themes from root cause analysis identified from local groups to identify the most appropriate actions to support organisational learning.
- Review all outstanding organisational actions required to effect organisational learning
- Identify themes arising from recommendations.
- Liaise with the Clinical Effectiveness Group in relation to audit and re-audit of actions and recommendations to measure impact on organisational learning and clinical outcomes.”

3.6.14 All patient safety incident reports are a standing agenda item for discussion at regional clinical governance group meetings.

3.6.15 The policy outlines the steps within the process to identify, implement, monitor, test and report learning point outcomes following adverse events. The policy states that:

“Learning from experience is one of the fundamental aspects of Patient Safety incident investigations. NHS 24 aims to ensure learning is communicated to ensure a more effective and efficient service while delivering patient care.

“NHS 24 fully supports and promotes the need to share learning from patient safety incidents, whilst ensuring that information relating to a Patient Safety Incident Investigation is treated in a confidential manner.”

3.6.16 NHS 24 uses a variety of routes to share learning with staff. This includes emails to operational staff, ‘hot topic’ messages, critical messages displayed on plasma screens or formal updates through the performance management process.

3.6.17 NHS 24 reported that the hot topics are available in both email and hard copy format as part of a national weekend bulletin:

“These Hot Topics are from Partner Feedback, 3C’s and Formal Complaints received during the past week. These are agreed at the Regional Clinical Governance Meetings and approved by senior clinicians. We would encourage all staff to approach their Team Leader or Clinical Governance, Quality & Patient Safety Lead if they would like to discuss further.”

3.6.18 NHS 24 informed us that key messages are currently added to computers for staff to read, before they log in. NHS 24 plans to introduce a new customer relationship management tool which will make it mandatory for staff to read these communications before they can log on. We identified this as good practice.
3.6.19 Some staff informed us that they would welcome highlighted emails to help them prioritise what they need to read at the start of a shift. This would be particularly useful for staff who have just returned from leave.

3.6.20 The 3-monthly national patient safety and performance report highlights thematic learning and is presented through the organisational structure. NHS 24 informed us that a copy of the report is distributed to all clinical service managers and team leaders for discussion with their team members. However, NHS 24 acknowledges that staff members do not always receive a copy of the report or are aware of its contents.

3.6.21 Two out of the four cases we reviewed used a combined organisational learning action plan tracker to record both learning points and actions. The other two cases had no evidence of a specific learning summary.

3.6.22 Three of the cases had evidence of learning being shared with frontline staff, clinicians or team leaders through emails, hot topic bulletin or magazine article. The fourth case had no evidence of learning being shared. However, we saw evidence in this case of a suite of demonstration calls being compiled to support staff training through scenario and role playing.

3.6.23 Two of the cases had a checklist in place for nurse practitioners to confirm that they had read the learning points from the patient safety incident. We noted this as good practice.

3.6.24 The two cases that originated through partner feedback had evidence of progress updates and the final investigation report being shared with the relevant partner organisation.

3.6.25 NHS 24 reported plans to develop an audit programme to track the impact of recommendations or actions arising from patient safety incidents.

3.6.26 Our discussions with frontline staff revealed that they would welcome more information on how adverse events result in service improvements. All staff we spoke with were aware of learning mechanisms including emails and hot topic bulletins. However, frontline staff were not always aware that generic learning messages were a result of recommendations from specific adverse event investigations.

3.6.27 We noted that staff would benefit from more detailed learning messages including information on the context, how the learning was identified, and why improvements were being implemented. NHS 24 may wish to consider using patient stories to help share learning and to make the learning more relevant for particular grades of staff.

**Recommendations**

To improve timely management, learning and dissemination following adverse events, NHS 24 should:

7. strengthen the process for monitoring patient safety incident investigation timescales, review reasons for any delays and ensure timescales are met, and

8. provide more detailed learning messages to staff including information on the context, how the learning was identified, and why improvements were being implemented.
Appendix 1 – Details of review team

The review of NHS 24 was conducted on Thursday 31 October 2013.

Review team members

Mark Aggleton
Senior Business Manager, Healthcare Improvement Scotland

Ken Barker
Public Partner

Michele Caldwell
Director of Pharmacy, NHS Ayrshire & Arran

Nanisa Feilden
Programme Manager, Healthcare Improvement Scotland

Kevin Rooney
Consultant in Anaesthesia & Intensive Care Medicine, NHS Greater Glasgow and Clyde

Edel Sheridan
Project Officer, Healthcare Improvement Scotland

Hilary Walker
Safety, Governance & Risk Co-ordinator/Lead for Risk, NHS Tayside

Observed by:

Leslie Marr
Programme Manager, Healthcare Improvement Scotland
We can also provide this information:

- by email
- in large print
- on audio tape or CD
- in Braille (English only), and
- in community languages.