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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 National Waiting Times Centre’s governance arrangements and processes for managing adverse events involved:

- an analysis of evidence provided by the NHS board, and
- a visit to NHS National Waiting Times Centre on Wednesday 10 April 2013.

We found that NHS National Waiting Times Centre had comprehensive policies and guidance in place which clearly set out the benefits of reporting and effective management of adverse events. We also noted that improvement work was underway to address the recommendations from the NHS Ayrshire & Arran report.

We identified the following areas of good practice within NHS National Waiting Times Centre:

- a positive focus on ensuring patient and family involvement
- a strong mechanism for escalating and monitoring incidents at the clinical governance groups
- a good approach to recording and monitoring actions which will be enhanced by the planned work for ongoing improvement, and
- a willingness from all staff to look at challenges and learn from these in order to improve the management of adverse events.

However, we felt that the electronic systems could be used more fully to take advantage of the full capacity available and to maximise the efficiency of the reporting process. We also noted that although the training currently in place within the NHS board is adequate for the nature of the NHS board, regular training in line with the planned sustainable strategy for training and education would improve this area. The recommendations below aim to support NHS National Waiting Times Centre’s ongoing improvement work.
Recommendations

We expect NHS National Waiting Times Centre 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 National Waiting Times Centre’s active and planned approach to engaging with key stakeholders affected by a significant adverse event should:

1  involve and engage staff members more fully in the review process, and
2  ensure a consistent approach to patient, family and carer involvement which is formally documented and recorded.

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 National Waiting Times Centre should:

3  evidence that all staff receive training in incident management at regular intervals.

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.

To ensure clear functions and roles, NHS National Waiting Times Centre should:

4  demonstrate that review teams are multidisciplinary, and
5  ensure that staff are clear about their responsibilities when carrying out a review.
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 National Waiting Times Centre should:

6 ensure information management systems are integrated to provide a robust audit trail
7 demonstrate a consistent approach to providing individuals involved in incidents with feedback
8 evidence that the reporting system is used as fully as possible to send automatic email alerts and store relevant documents, and
9 demonstrate that the system allows thematic learning to take place.

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 National Waiting Times Centre should:

10 continue to ensure decisions about the management of adverse events are recorded and demonstrate that they are attached to the Datix record.

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 National Waiting Times Centre should:

11 ensure appropriate staff are involved in the development of action plans
12 demonstrate that reporting and investigation timescales are adhered to, and
13 evidence a consistent mechanism of sharing learning across the organisation, with a focus on driving improvement.

We have asked the NHS board to develop an improvement plan to address the identified recommendations.
We would like to thank NHS National Waiting Times Centre and in particular all staff at the Golden Jubilee National Hospital for their assistance 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 National Waiting Times Centre 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 14 adverse events graded as high or very high over the past 18 months, and
- details of four specific adverse event reviews.
1.1.8 We selected four cases for detailed review. We selected the three adverse events that had undergone the highest level of review, and selected one other by reviewing the high level summary of each case, taking into the location and specialty of the event and the level of investigation.

**Review visit**

1.1.9 The review visit took place on Wednesday 10 April 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. The chief executive of NHS National Waiting Times Centre was interviewed on 17 April 2013 as she was unable to attend on the day of the visit.

1.1.11 We discussed the initial findings of our report with NHS National Waiting Times Centre’s nurse and medical directors on 24 April 2013.

**Improvement plan**

1.1.12 We expect NHS National Waiting Times Centre 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 National Waiting Times Centre 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 National Waiting Times Centre’s adverse event management policies and procedures

2.1.1 NHS National Waiting Times Centre is an NHS special board which exists as a national resource for NHSScotland. It carries out a range of planned procedures to assist other NHS boards in reducing patient waiting times and is also home to a range of regional and national services.

2.1.2 The Golden Jubilee National Hospital, Clydebank, is the only facility in this NHS board and receives referrals to reduce patient waiting times in key elective specialties. It is a major centre for orthopaedics and has a responsibility for a range of regional and national heart and lung services. The hospital employs over 1,400 staff from a wide range of professional and support occupations, and has over 200 beds, four cardiac catheterisation laboratories, and 16 theatres.

2.1.3 NHS National Waiting Times Centre outlines a commitment to a supportive, open and learning culture that encourages staff to report adverse events and mistakes. The NHS board aims to learn and improve practice as a result of incidents as outlined in their incident reporting policy and procedure which is supported by the risk management strategy. This will hereafter be referred to as the incident reporting policy.

Adverse event definitions

2.1.4 NHS National Waiting Times Centre sets out the following definitions in their incident reporting policy (version 8, issue date August 2012):

- Serious adverse event: any unintended or unexpected adverse incident that could have or did lead to major permanent harm, loss or damage. A SAE may seriously impact upon the delivery of objectives and which may attract adverse media attention and/or result in litigation or which may reflect a serious breach of standards for assuring the quality of the Board’s services and its reputation.

- Adverse incident: any event or circumstance that led to unintended or unexpected harm, loss or damage.

- Near miss: incidents that did not lead to harm, but could have.

- Harm: 'injury (physical or psychological), disease, suffering, disability or death'. In most instances, harm can be considered to be unexpected if it is not related to the natural cause of the patient’s illness or underlying condition.

2.1.5 NHS National Waiting Times Centre uses the electronic reporting system, Datix, to record and categorise adverse events. The person reporting must estimate the severity by selecting one of the four gradings on Datix, based on the NHSScotland Risk Matrix:

- very high
- high
- medium, or
- low.

2.1.6 The NHS board has categorised a significant adverse incident as those rated as “very high”. All such incidents will be subject to root cause analysis. Those rated as “high” or “very high” will be investigated by an interim incident review. During an interim...
incident review the team will complete a report and make a recommendation as to whether a root cause analysis is required.

2.1.7 During the 18 month period between January 2011 and July 2012, there were a total of three adverse incidents which were subject to a root cause analysis. One of these cases was escalated from an interim incident review to a root cause analysis. There were a total of 11 adverse events that were subject to an interim incident review.

2.1.8 NHS National Waiting Times Centre identified that all 14 of the incident cases, subject to a root cause analysis or interim incident review, were of a clinical nature.

**Governance arrangements**

2.1.9 Within the NHS National Waiting Times Centre Board, the chief executive is the accountable officer for risk management to ensure that the NHS board adheres to all health and safety legal requirements. In practice, the chief executive delegates responsibility to the following individuals:

- assigned managers (for specific investigations)
- clinical governance and risk management development unit
- divisional management teams including senior nurse managers
- head of clinical governance
- nurse director, and
- ward/department line managers.

2.1.10 Incidents graded as “very high” are tabled for discussion at the following governance meetings:

- audit committee
- the Board
- clinical governance and risk management group
- divisional clinical governance group
- health and safety committee, and
- specialist committees.

2.1.11 Figure 1 outlines the current governance arrangements in place for the management of adverse events. Over the last 5 years, the NHS board has reviewed, and subsequently made changes to, their governance arrangements to ensure effectiveness.
Figure 1: NHS National Waiting Times Centre 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.

Patient, family and carers involvement

3.1.1 The NHS National Waiting Times Centre incident reporting policy provides guidance to ensure the involvement of patients following an adverse incident.

3.1.2 The incident reporting policy states:

“Following a serious adverse event, it is expected that at all times appropriate information is communicated to patients, staff or other persons involved in the incident. Information will include a full explanation about what has happened including any implications that may affect them. In the event of an incident that has resulted in harm to a patient this should be done in conjunction with the patient's consultant, or if a staff member a designated Senior Manager of the Board (designated by senior manager on call or member of the executive team). These discussions must always be documented.”

3.1.3 The National Reporting Learning System guidance - Being Open: Communicating Patient Safety Incidents with Patients, their Families and Carers (2009) is also provided within the NHS board incident reporting policy which outlines how to communicate effectively with patients, their families and carers following harm through five stages:

- incident detection or recognition
- preliminary team discussions
- initial “being open” discussion
- follow-up discussions, and
- process completion.

3.1.4 Of the four cases reviewed, we did not find a consistent process for involving patients, family and carers in the incident investigation. In three of the cases, the patient and/or family were provided with the final report. In the fourth case, evidence was supplied outlining the intention to hold a meeting. However, in this case, there was no evidence of involvement during the investigation process.

3.1.5 Staff spoken with during the review told us that patients and family had been invited in to attend meetings and had been updated throughout the investigation process. This was done by email, letter and telephone discussion, but had not been formally documented. Staff further reported that occasionally family members do not want to attend meetings and be part of the investigation process and would prefer to know that the incident is being investigated with the aim to prevent similar incidents happening again. The clinical governance and risk management development unit outlined that a “free access to all” approach is taken towards information about incidents and associated investigations. This was re-emphasised by the chief executive.
3.1.6 Staff spoken with during the review identified that this was an area that could be improved upon and the NHS board had already taken steps to do so. A care following death policy has been developed which outlines the procedure to be followed in the event of a death. This policy provides guidance in the form of a process map for liaising with family and carers following the death of a patient. The NHS board told us about further future plans over the next 6 months to extend and develop this policy to address all significant adverse events.

3.1.7 The incident management action plan developed by the NHS board outlined that the plan to extend the care following death policy was due to be discussed at the quality patient public group in May 2013 to receive input for former patients and the public.

Staff involvement

3.1.8 All staff within NHS National Waiting Times Centre have access to report incidents within the Datix system and the incident reporting policy provides them with guidance.

3.1.9 The incident reporting policy states that line managers are responsible for the provision of support for staff, and outlines a variety of ways which support can be provided:

- debrief following incident
- health and safety department
- occupational health department
- pastoral care, and
- spiritual care.

Staff spoken with throughout the day confirmed that they felt supported following incidents as well as during the review process.

3.1.10 Analysis of evidence provided by the NHS board before the visit documented that staff were invited to interview as part of the review process and were provided with the final report. However, there was no evidence that staff involved in the incident were engaged more fully in the review process, for example in analysing events or shaping recommendations. Staff spoken with during the review visit confirmed that this was the case. We also noted that membership of the review team generally comprised of surgical and medical staff members rather than a more multidisciplinary team.

3.1.11 The incident reporting policy states that line managers are to:

“provide feedback to staff regarding action taken as a result of reporting an incident, a minimum of monthly intervals, at department meetings.”

This was confirmed by discussion with the senior management team who told us that interim updates during the review are provided to staff by line managers. They acknowledged that this process is not followed in all areas, and is generally seen to be better in nursing rather than medical specialties. Staff spoken with during the review visit confirmed that feedback was provided to them throughout the investigation process.

3.1.12 To provide further support for staff, the senior management team reported that it is currently working on developing and implementing “Schwartz rounds”. This allows all
staff to openly discuss any issues surrounding patient care, and focuses on social and emotional issues that can arise when caring for patients.

3.1.13 Staff spoken with during the review told us that they were not directly involved in creating action plans following an incident review. However, they did tell us that they were supported in the implementation of the actions. The senior management team further added that during the development of the action plan, there was a strong emphasis on creating genuinely achievable actions.

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

1. involve and engage staff members more fully in the review process, and
2. ensure a consistent approach to patient, family and carer involvement which is formally documented and recorded.

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 The NHS board incident reporting policy states:

“All staff attend corporate induction where a focus is around incident reporting and complaints management. Induction includes familiarisation with the Datix system and the principles of incident reporting and is reinforced using scenarios.

“Training on the use of Datix is provided by the risk officer to all staff on request. Training is tailored to meet the need of the individual (may cover basic use of Datix through to advanced reporting) and is followed up by ongoing support to staff.

“Training is also provided to Charge Nurses on an annual basis. These workshops focus on principles of incident reporting as well as practical challenges faced by staff.”

3.2.2 The senior staff and clinical governance and risk management development team reported that the induction training for the management of adverse events has been adapted to look at real incidents to provide a rationale for the processes that are to be followed. Scenario-based discussions are also used to further embed an understanding of the incident reporting policy and associated procedures.

3.2.3 Staff spoken with during the review told us that they had all received training on Datix, and were comfortable in approaching the clinical governance and risk management
development unit to request updates or further training. Staff also reported that support was given locally within departments when required.

3.2.4 There did not appear to be a consistent approach to investigation training. Some staff reported that investigation processes were learned during the course of the investigation. Staff who had been trained in investigation techniques were generally from a medical specialty background.

3.2.5 The clinical governance and risk management development unit confirmed that there had not been an investigation training session in the last few years. This was due to the nature of staff turnover within the NHS board, as trained staff have remained working within the NHS board. However, investigation training has been planned for May 2013 in order to widen the pool of staff with the required training to participate in review teams.

3.2.6 An action plan dated April 2013, developed by the NHS board, outlines a sustainable strategy for all areas within training and education of incident reporting management including:

- communications with all stakeholders
- general awareness
- investigation management, and
- use of Datix.

**Recommendations**

To support staff knowledge and training, NHS National Waiting Times Centre should:

3 evidence that all staff receive training in incident management at regular intervals.

### 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 incident reporting policy outlines the roles and responsibilities for members of staff, managers, departments and committees. Individuals to be alerted following an incident is outlined as:

- “During working hours: immediately inform the duty manager who will in turn contact CGRM/DMT/Chief executive/Nurse Director/Medical Director.

- “Out of hours: immediately inform a Senior Nurse who will inform the Duty Manager. These events must also be reported to the relevant CGRM/DMT/Executive Directors as soon as possible and within a maximum of one working day.”
3.3.2 The member of staff is then to complete a Datix form as soon as possible, within two working days. Line managers are to encourage all incidents to be reported and to assign a specific individual who is responsible for ensuring that all incidents during a particular shift are reported. Line manager responsibilities are outlined as:

“As soon as possible after the event, initial grading will be reviewed by the ward/department line manager who will either confirm or reduce down to the next grade. The line manager is responsible for reviewing and updating grading as required and, prior to closing in Datix, completion of an investigation and implementation of its action plan.”

3.3.3 Divisional management teams are accountable to the clinical governance and risk management group, and are responsible for ensuring:

- staff are aware of all procedures for reporting incidents
- provisions are made within their directorate for investigation
- learning is shared following incidents, and
- all actions following investigation are implemented.

3.3.4 The chief executive is the accountable officer for risk management within NHS National Waiting Times Centre. As chair of the clinical governance and risk management group, they ensure that the NHS board meets all health and safety obligations. The nurse director is designated as the executive lead for clinical governance and is responsible for the management of incidents.

3.3.5 The senior management team reported that the non-executive directors are all involved operationally within their respective committees, and have a keen interest in sharing learning throughout NHS National Waiting Times Centre.

3.3.6 The clinical governance and risk management development unit plays a key role in the management and investigation of incidents. For all reported incidents, a member of the team electronically confirms or amends the information recorded in the Datix report before escalation to the appropriate individual for further action. This process is followed for all adverse events regardless of severity. The team will not address all incidents that happen out-of-hours until the next working day.

3.3.7 Staff spoken with during the review were aware of their responsibility to report incidents and their role within the investigation. They also felt supported by the clinical governance and risk management development team.

3.3.8 The senior management team told us that staff were assigned to the review team based on their background knowledge of factors relating to the incident. Of the four cases examined, all members of the review team were of a medical or surgical background. The staff assured us that the investigation remained objective and professional regardless of the lack of cross-discipline representation.

3.3.9 Within the investigation process, all staff told us that they were clear on their assigned role within the review team. The clinical governance and risk management development unit co-ordinated the review. Staff spoken with during the review visit told us that support was provided in terms of guiding the team members through the review process.
Recommendations

To ensure clear functions and roles, NHS National Waiting Times Centre should:

4 demonstrate that review teams are multidisciplinary, and
5 ensure that staff are clear about their responsibilities when carrying out a review.

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.

3.4.1 NHS National Waiting Times Centre uses the Datix risk management system to report and record incidents as well as store documents related to incidents and associated investigations. The NHS board also uses a separate documentation management system, Q-pulse, and the organisation’s main file structure.

3.4.2 The NHS board incident reporting policy states that “the completed report and action plan will be incorporated into Datix.” The NHS board provided comprehensive evidence for each of the four selected cases before the visit. However, there was no evidence to determine whether information had been stored on Datix. It was confirmed during the visit that the bulk of the information was stored in the clinical governance and risk management development folders within the organisation’s main file structure rather than on Datix.

3.4.3 We were told by staff throughout the review visit that the clinical governance and risk management development unit acted as the “gate-keeper” for all documentation associated with adverse event management. Although we saw clear evidence that this met the current needs of the NHS board and provided an audit trail, we felt that it was an inefficient and person-dependent system which did not make the best use of the functions and potential of the Datix and Q-pulse systems. We also identified during the review that this way of working could sometimes cause problems in terms of version control.

3.4.4 During the review, we were given a demonstration of how the NHS board uses the Datix and Q-pulse systems. We were shown which functions were used and told that information, for example emails or review reports, is copied to the Datix record into the notepad application within the system.

3.4.5 The senior staff reported that they have looked into a replacement for the Datix system called “Quality Searchlight”. They outlined that this is a more interactive system which allows the upload of evidence and will allow feedback to be provided to staff automatically. Before changing, we would encourage the NHS board to discuss the potential of the current system with their system provider and other users, as we felt that there were many underused elements of Datix.

3.4.6 The incident reporting policy states the need to communicate with staff and provide them with relevant information. Staff told us that if they want information they would
go to their line manager or clinical governance and risk management development unit. The clinical governance and risk management development team then confirmed that they would be happy to provide staff with any information in relation to the investigation and final report.

3.4.7 The senior management team reported that updates and investigation reports are shared with staff involved in the incident. This is generally communicated by divisional management teams and line managers. The NHS board acknowledged that this area of the incident investigation process could be improved upon. Staff spoken with during the review confirmed this and told us that updates were provided to them during the course of the review, however it was not always shared in a consistent way.

3.4.8 We saw no evidence that Datix was used to support thematic learning. However the NHS board is currently developing the use of dashboards to recognise themes and correlate with clinical information and workforce action.

**Recommendations**

To support its information management processes, NHS National Waiting Times Centre should:

6 ensure information management systems are integrated to provide a robust audit trail
7 demonstrate a consistent approach to providing individuals involved in incidents with feedback
8 evidence that the reporting system is used as fully as possible to send automatic email alerts and store relevant documents, and
9 demonstrate that the system allows thematic learning to take place.

### 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 The incident reporting policy outlines that a Datix incident form is to be completed as soon as possible and within two working days following an adverse event. The grading of the incident is based on the NHSScotland Risk Matrix. The form is to be completed by the member of staff who first became aware of the incident.

3.5.2 Following the completion of the Datix form, a designated member of staff in the clinical governance and risk management development unit will then process the form and escalate to the appropriate senior management to progress to an investigation. During the visit, we were shown that this manual step had to occur before the alert was sent by Datix. The grading will then be reviewed, and subsequently amended or confirmed, by the ward/department line manager. Although the incident reporting policy outlines the formal steps to be taken to inform the appropriate managers, on the visit the staff told us that events were escalated quickly independently of the Datix system.

3.5.3 Of the four cases selected for review, the following investigations were carried out.
• Three cases were graded as high on the initial Datix form and subject to root cause analysis. One of these cases was initially investigated through the interim investigation review process and was later escalated to a full root cause analysis.

• One case was not reported through Datix as was raised verbally. Upon review, the NHS board recognise that this would now be input to the system regardless of how the concern was raised.

**Escalation of events**

3.5.4 The NHS National Waiting Times Centre incident reporting policy states:

• “Incidents graded as very high (significant adverse event which has resulted in death or major permanent harm), a root cause analysis will be carried out.

• “Incidents graded as high/very high (incident which may have resulted in death or major permanent harm), an interim investigation review will be undertaken. This may progress to a full root cause analysis if considered necessary following the completion of the interim investigation review.”

3.5.5 Divisional management teams meet weekly to review all adverse events reported through Datix from the previous week. These reviews also look at interim investigation review and root cause analysis final reports to ensure accuracy of content and to confirm recommended actions.

3.5.6 The clinical governance and risk management development unit reported that all decisions about escalation of incidents and associated investigations are recorded on Datix. Following examination of Datix records provided by the NHS board before the review visit, these documents did not appear to be uploaded.

3.5.7 Information provided relating to all four cases showed that there are robust mechanisms in place to escalate to the clinical governance groups and to the chief executive as appropriate:

• All incident reports are discussed at the clinical governance and risk management group where recommendations and actions are approved, these are then monitored by the divisional clinical governance groups.

• Progress of all incidents are reported four times a year to the relevant clinical governance group.

• Any outstanding actions relating to incidents are scrutinised at the clinical governance and risk management group.

3.5.8 Case evidence also showed that that decision-making around level of review required is effectively documented.

**Recommendations**

To support a risk-based, informed and transparent approach, NHS National Waiting Times Centre should:

10 continue to ensure decisions about the management of adverse events are recorded and demonstrate that they are attached to the Datix record.
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 NHS National Waiting Times Centre’s incident reporting policy states that for all incidents, an electronic incident report should be completed “as soon as possible and within two working days.”

#### 3.6.2 Of the four cases reviewed, one was reported on Datix within one day of the incident occurring, one was reported within two days, and one within 15 days. The fourth was not reported via Datix.

#### 3.6.3 The incident reporting policy outlines the key performance indicators (KPIs) which investigations should meet:

- **KPI 1** - All Datix forms will be processed within three working days of being entered onto the system.
- **KPI 2** - All electronic incident forms must be fully completed within three working days.
- **KPI 3** - All medium and low incidents will be closed within 14 working days of being processed.
- **KPI 4** - When a very high/high incident trigger is activated response required in two working days.
- **KPI 5** - All IIRs will be closed within 14 days of being commenced.
- **KPI 6** - All RCAs will be closed within agreed timescales not normally longer than three months.

#### 3.6.4 Of the three cases that were subject to a root cause analysis, none of these met the timescale set out by KPI 6. The investigations took between four and seven months to close. The interim investigation review investigation did not meet KPI 5, and took one month to close.

#### 3.6.5 The NHS board identified that meeting the planned timescales was a challenge and their action plan dated April 2013 detailed that a review of KPIs had occurred and that work was under-way to make all staff fully aware of expectations of timescales for the management of adverse events. The updated KPIs are due to be agreed at the clinical governance and risk management group in May 2013.

### Action planning

#### 3.6.6 The NHS board incident reporting policy states that as part of the root cause analysis, the team is to:

- determine actions and recommendations to ensure effective learning from incidents
- monitor implementation of actions and recommendations, and
• ensure that lessons learned are shared and applied across the NHS board, if appropriate.

3.6.7 All four of the cases reviewed contained action plans. These included the responsible member of staff for each action and the required timescale for completion. For two of the cases, we received evidence that actions were monitored and final completion dates recorded.

3.6.8 Staff spoken with during the course of the review reported that the investigation team developed the action plans. The departmental staff who were responsible for implementing the actions were not involved in the development of the initial action plans. However, the staff spoken with on the review visit told us that they were engaged and supported during the implementation.

3.6.9 Staff further reported that many of the actions included in the formal action plans developed by the review team had been immediately put into place following the incident at a local level.

3.6.10 The senior staff and clinical governance and risk management development team told us that actions from all investigations are updated and monitored as a standing item at weekly divisional management team meetings. These then provide status updates to the divisional clinical governance groups for those incidents with a high/very high grading. These groups are accountable to the clinical governance and risk management group which provide quarterly update reports to the sub-committees of the Board:

• person centred committee
• clinical governance committee, and
• audit committee.

3.6.11 The NHS board incident reporting policy outlines in relation to the above mentioned committees:

“Incidents should remain on the agenda until the committee are satisfied that desired outcomes have been fully achieved and the committee may request evidence to confirm this.”

3.6.12 The clinical governance and risk management development unit tracks all actions developed as part of investigations. This is done through a central spreadsheet and can be accessed by way of divisional management teams. However, ownership is retained by the clinical governance and risk management development unit.

Sharing of learning

3.6.13 NHS National Waiting Times Centre’s incident reporting policy promotes the importance of sharing learning across the organisation to prevent incidents happening again.

3.6.14 Before the review visit, the NHS board evidenced that learning relating to only one case had been shared within the organisation. The incident was reported on the staff intranet page, together with appropriate lesions learned and guidance on how to apply them. Senior management, and staff spoken with, told us that due to the nature of the board, learning is shared almost immediately by word of mouth. Staff reported that formal measures were also used to share learning:
• through divisional management teams who cascade information to local teams
• by posting noticeboards in staff areas, and
• by building lessons learned from incidents into existing events.

3.6.15 Although staff reported and evidenced various methods of sharing learning across the NHS board, there did not appear to be a consistent method to ensure efficient circulation within the organisation and effective implementation of actions. The action plan dated April 2013 reported that plans were in place to publish a quality bulletin which will outline areas of improvement and good practice within the organisation. This had not yet been started at the time of the visit, but it had been agreed to incorporate articles in the weekly e-bulletins.

3.6.16 The clinical governance and risk management development unit reported that themes are identified by way of the central tracking spreadsheet and dashboards. High level themes are identified and are then discussed with divisional clinical governance groups and the recently formed quality and innovation group to develop further actions if required.

3.6.17 The action plan dated April 2013 outlines the plan to review reporting arrangements to ensure a consistent approach for reviewing outcomes, sharing learning and implementation of appropriate improvement. Workshops and discussions had been held before the review visit to progress these plans.

**Recommendations**

To improve timely management, learning and dissemination following adverse events, NHS National Waiting Times Centre should:

11 ensure appropriate staff are involved in the development of action plans
12 demonstrate that reporting and investigation timescales are adhered to, and
13 evidence a consistent mechanism of sharing learning across the organisation, with a focus on driving improvement.
Appendix 1 – Details of review team

The review of NHS National Waiting Times Centre was conducted on Wednesday 10 April 2013.

Review team members:

**Mark Aggleton**  
Senior Business Manager, Healthcare Improvement Scotland

**Phillip Cachia**  
Post Graduate Dean for East of Scotland and Executive Lead for Patient Safety and Clinical Skills, NHS Education for Scotland

**Jenny Long**  
Programme Manager, Healthcare Improvement Scotland

**Margaret McGuire**  
Nurse and Medical Director, NHS Tayside

**Claire Scrim**  
Project Officer, Healthcare Improvement Scotland

**Jim Wilson**  
Public Partner

**Sheena Wright**  
Director of Nursing and Care, NHS 24

**Observed by:**

**Marguerite Robertson**  
Public Partner
We can also provide this information:

- by email
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The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, and the Scottish Intercollegiate Guidelines Network (SIGN) are part of our organisation.