Adverse Events Notification System: Update Report

January 2022
Healthcare Improvement Scotland is committed to equality. We have assessed the review function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Advisor on 0141 225 6999 or email his.contactpublicinvolvement@nhs.scot
Introduction

This report covers the timeframe from commencement of the notification system in January 2020 to October 2021. The launch of the notification system commenced shortly before the national COVID-19 pandemic. Therefore, much of the work to date has been taken forward during a period of unprecedented pressure for NHS Scotland. As such, this report provides an update on work undertaken so far and sets out plans for the next phase of work.

Background

In September 2013, Healthcare Improvement Scotland (HIS) developed and published the first edition of the Learning from Adverse Events through Reporting and Review: A National Framework for Scotland\(^1\) (the framework) following extensive consultation and engagement across Scotland. This framework sets out to make sure that no matter where an adverse event occurs in Scotland:

- The affected person receives the same high quality response.
- Organisations are open, honest and supportive to the affected person, apologising for any harm that occurred.
- Any staff involved are supported in a consistent manner.
- Events are reviewed in a consistent way and learning is shared and implemented across the organisation and more widely to improve quality of services.

The framework includes a national definition of an adverse event, guidance on reporting, accountability, responsibilities and learning and principles for an open, just and positive safety culture. It provides definitions, tools and supporting documentation based on the six stages to managing an adverse event.

The six stages are described as:

1. risk assessment and prevention
2. identification and immediate actions following an adverse event
3. initial reporting and notification
4. assessment and categorisation
5. review and analysis, and
6. improvement planning and monitoring.

\(^1\) The current version of the national framework (4\(^{th}\) edition) was published in December 2019.
The framework states that every event should be reviewed, but the level of review will be determined from the category of the event and other factors such as the potential for learning. The framework also states that organisations should develop their own local policies and procedures to support the implementation of this nationally defined process. NHS boards will assume responsibility for the governance and subsequent learning from adverse events.

In September 2019, HIS published the Adverse events management: NHS board self-evaluation report. The report highlighted significant variations in the way that NHS boards in Scotland were managing and learning from adverse events. In response to the report, the Cabinet Secretary for Health and Sport on 10 September 2019, instructed HIS to take forward actions that require all NHS boards to notify HIS when they have commissioned a Significant Adverse Event Review (SAER) for a Category I adverse event.

There was an additional ask for HIS to work with NHS boards to support them in standardising terminology and definitions, including the implementation across all NHS boards of the consistent use of SAER.

Our Approach

In order to support NHS boards in standardising terminology and definitions and support implementation of the adverse events notification system, HIS adopted a whole systems approach, part of which, was the establishment of an expert reference group (ERG) in October 2019. This group was designed to support the development and implementation of a national notification system for Category I, SAERs. The membership of the group was made up of governance and risk leads from NHS boards who were already key members of the existing adverse events network.

The instruction from the Cabinet Secretary also outlined a 12 week turn around for the development and implementation of a new notification system. There was no existing software available that could be used across NHS boards and it was agreed, due to tight timeframes, that a manual process for recording adverse events be created as a short term measure. This manual system has proved to be both challenging and time consuming. Therefore, work is underway to identify a digital system, within existing resource, to replace the current manual system. HIS have been in contact with other UK nations who have successfully implemented a national digital notification system and the learning from other nations is currently being considered as part of the identification of a new and improved Scottish system. This will be taken forward in phase two of this programme.

On the 1 January 2020 the manual notification system went live. From this date all NHS boards were required to notify HIS of all Category I adverse events receiving a SAER. The framework advises that all adverse events should receive an appropriate

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2 The highest level of review, also referred to as a Level 1 review.
level of review. However, Category II and III events and Level 2 and 3 reviews do not fall within the national notification requirement.

**NHS Boards**

Since January 2020, all NHS boards have engaged fully with the notification system. Monthly notification data has been received from all organisations. Representatives of NHS boards with responsibility for adverse events have met together regularly as part of an adverse events network facilitated by HIS. This network has provided a forum for members to work together to learn from each other and to take forward areas for improvement.

The adverse events network, which is a wider stakeholder group and includes representation from all NHS boards with the addition of some additional clinical experts, has now become the vehicle for driving this work forward.

After only three months of the notification system being in place, the UK went into a national lockdown due to the COVID-19 pandemic. Submission of data was paused between March and June 2020 to relieve pressure on NHS boards during the height of the pandemic. During this time period NHS boards were still required to follow the national framework and continue to record adverse events at a local level using their own incident management software. Submission of data for this specific time period was resumed by HIS from July 2020 when the notification system was re-started.

Throughout the pandemic, HIS have continued to communicate with NHS boards to offer support. NHS boards have shared with us the unprecedented pressures they have experienced and the challenges they have faced in recording and reviewing their adverse events. We were also advised that any paused reviews were subsequently resumed and that patient and family engagement was maintained throughout this period. Data collected between March and June 2020, showed that several NHS boards experienced delays in meeting the 90 day SAER completion target. However, it should be noted that this was a pre-existing issue for some NHS boards before COVID-19.

During April and May 2021, HIS conducted a series of individual meetings with representatives from each NHS board with a view to understanding their experience of the notification system and to gather views around potential improvements. Priorities for the development of the notification system and associated improvement work were also identified at these meetings.
Lessons learned

Each month, on average, NHS boards notified HIS of approximately 50 Category I, SAERs (Appendix 1a). The period between March and April 2020 saw a notable reduction in notifications which coincided with the first UK COVID-19 wave and subsequent national lockdown. NHS boards informed us that this was due to the reduction in non-critical services and the associated drop in bed usage for these services.

The notification system requires NHS boards to notify HIS of the type of adverse event (Appendix 1b). In so doing, it quickly became apparent that the description of the type of adverse event varied significantly across NHS boards. HIS responded to this issue by simplifying the event types by means of reduction of options. Thematic analysis of the data allowed HIS to identify the most reported event types which were:

- unexpected death
- suicide
- treatment
- diagnosis, and
- falls.

The most reported areas of specialty\(^3\) were:

- mental health
- maternity/obstetrics
- surgical
- accident & emergency, and
- patient transfer.

The variation in event type and specialty descriptions created significant differences in the number of reviews undertaken within each event type (Appendix 1c). For example, some NHS boards initially notified and classified a suspected suicide as an unexpected death until the full completion of the SAER and confirmation of completed suicide.

Following this early analysis of data, it was clear that significant work is required to achieve robust data management, analysis and national standardisation. Moving

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3 A medical specialty is a branch of medical practice that is focused on a defined group of patients, diseases, skills, or philosophy. Examples include children (pediatrics), cancer (oncology), laboratory medicine (pathology), or primary care (family medicine).
forward, a whole systems approach with a strong commitment from NHS boards will be required to address this.

NHS boards have already begun work in this area with slips, trips and falls being identified as the first event type to be standardised. This work is being led by the national risk advisor for the HIS and NHS Education for Scotland (NES) Joint Commission for Openness & Learning⁴ (joint commission) and will be supported through the adverse events network.

The next stage of this standardisation process will look at suicide and unexpected deaths. A key area of focus will be mental health services who have the largest number of SAER’s reported within the service speciality category for these events.

**Joint Commission for Openness & Learning**

To further strengthen our approach to supporting NHS boards, the joint commission has formed part of our whole systems thinking and we have actively encouraged NHS boards to engage with this. Many of the NHS board representatives were already existing members of the adverse events network and were ideally placed to link this work to their existing local adverse events processes.

Adverse events should be regarded as an opportunity to learn, to improve and to increase the safety of our care system, for everyone. The joint commission is a collaboration between HIS and NES and aims⁵ to:

- Explore opportunities for patient, carer, families and staff involvement in healthcare improvement, openness and learning.
- Increase the quality and credibility of incident investigation.
- Increase the quality of organisational and national learning.
- Decrease the potential of adverse event recurrence.

This work aims to understand patient safety from multiple perspectives through engaging with key stakeholders, exploring the current systems, and exploring opportunities for improvement, including learning to be gained from other safety critical organisations. For example, criminal justice and aviation. The joint commission supports a national approach to the identification, review, reporting and learning from adverse events and focuses on ‘what enables things to go right’. The joint commission is committed to identify what good patient involvement looks like as part of improving patient safety in health care.

A research study is currently underway to explore what might help or hinder patient, carer and family involvement in adverse event reviews. A full report of this research is

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⁴ Scottish Government instructed HIS and NES to collaborate to create more coherent local and national learning systems from adverse events.

⁵ These aims are subject to revision following stakeholder consultation and engagement phase.
due to be published in early 2022. This report will also inform the continued work of the adverse events programme to improve patient and family engagement during SAERs.

The joint commission in collaboration with NHS boards, will aim to develop a learning system for capturing and sharing of learning nationally. It is anticipated that this will replace the existing adverse events community of practice. This is an opportunity to modernise the existing system and to expand existing support provided to NHS boards around the management of adverse events. The approach will look at a variety of methods, including human factors and the utilisation of the existing Quality Management System, where a coordinated and consistent approach leads to a well-developed learning system.

Next steps – Phase Two

Phase two of this work will continue to focus on a high quality response to adverse events, supporting openness, honesty and consistency of approach. The priority areas of work which are planned for the first 12 months of phase two are:

1. **Standardisation**

HIS will work with NHS boards and other stakeholders to support the establishment of an agreed national approach to standardising all aspects of the notification system as follows:

- Event/Incident Type
- Event/Incident Sub-type
- Specialty
- Outcome Code

Applying standardisation to the level of review an adverse event receives will provide assurance that the most serious of adverse events are managed consistently across NHSScotland. This will support NHS boards to provide assurance to the public that no matter where the adverse event takes place in Scotland, the same level of review will be undertaken.

In order to fully understand and implement the changes required to achieve a national approach to the management of adverse events, NHS boards are required to work together to support achieve this aim.

2. **Digital Solution**

HIS will work with the adverse events network and other stakeholders to explore options for an improved notification system through refining the use of existing systems and technology. Together we will seek to understand the experiences of the
other four nations, some whom have successfully implemented a national digital system.

3. Multi-disciplinary Suicide Reviews

In addition, HIS will continue to work with partners from the Convention of Scottish Local Authorities (COSLA) and the Mental Welfare Commission for Scotland to support the development of a multi-disciplinary suicide review which links to the Scottish Government’s Suicide Prevention Action Plan: Every Life Matters. It is anticipated that this will be linked into phase two of the programme to allow NHS boards to involved in and influence these discussions.

Work will commence on stage two of the notification system in January 2022 and the milestone for reporting is expected by winter 2023. This is to allow appropriate time for the significant standardisation work to be developed and implemented and to allow for any national data trends to be identified in time for phase two reporting. A further report will be published to update on progress and milestones achieved in due course.
Appendix 1a

Total Number of SAERs reported to HIS

Data submission to HIS commenced in January 2020 and the approach to this subject to further development and standardisation of reporting.
Appendix 1b

Type of Adverse Event (Jan 2020 – October 2021)

Data submission to HIS commenced in January 2020 and the approach to this subject to further development and standardisation of reporting.
Appendix 1c

Specialty (Jan 2020 – October 2021)\(^8\)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>264</td>
</tr>
<tr>
<td>Maternity/Obstetrics</td>
<td>70</td>
</tr>
<tr>
<td>Surgical</td>
<td>68</td>
</tr>
<tr>
<td>Accident and Emergency</td>
<td>60</td>
</tr>
<tr>
<td>Patient Transfer</td>
<td>56</td>
</tr>
</tbody>
</table>

\(^8\) Data submission to HIS commenced in January 2020 and the approach to this subject to further development and standardisation of reporting.