Management of adverse events

Review Report | NHS Tayside

September 2013
Healthcare Improvement Scotland is committed to equality. We have assessed the review process 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 Officer on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive summary</td>
<td>4</td>
</tr>
<tr>
<td>1  Introduction</td>
<td>8</td>
</tr>
<tr>
<td>2  NHS Tayside’s adverse event management policies and procedures</td>
<td>10</td>
</tr>
<tr>
<td>3  Detailed review findings</td>
<td>15</td>
</tr>
<tr>
<td>Appendix 1 – Details of review team</td>
<td>33</td>
</tr>
</tbody>
</table>
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 Tayside’s governance arrangements and processes for managing adverse events involved:

- an analysis of evidence provided by the NHS board, and
- a visit to NHS Tayside on Wednesday 17 July 2013.

NHS Tayside has plans to improve how it manages adverse events. The NHS board began fully using the Datix system on 1 April 2013 and intends to further develop the way in which Datix can support the management of adverse events.

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

- engagement with patients and their families following adverse events
- staff engagement with incident reporting and significant clinical event analysis
- clear and consistent processes to ensure leadership and accountability in the management of significant adverse events, and
- co-ordinated support provided by the clinical governance and risk team including guidance and templates for the investigation process.

We identified a number of challenges in how adverse events are managed consistently across the NHS board. We found further improvements could be made in relation to information management systems, the robustness of local reviews, organisation wide sharing of learning and assurance that this has led to improvements.

Recommendations

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

1. finalising the draft patient/family information leaflets and demonstrating that these are used consistently
2. continuing to implement the planned changes to the NHS board’s new Datix system to ensure staff involved in incidents have access to timely feedback, and
3. agreeing the approach to sharing more detailed review reports, learning and actions across the organisation.

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 Tayside should:

4. carry out the actions identified in its implementation plan to improve training of incident verifiers and reviewers, and
5. ensure staff have a clear understanding of investigation techniques/methodology to support consistency in incident reviews and action planning, and are able to implement a standard approach for standard significant event analysis investigations, including the use of templates.

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 Tayside should:

6. clarify the role of the clinical quality forum in reviewing significant clinical event analyses, and
evidence adverse event information being fully reported and discussed at governance meetings to support clear oversight of how adverse events are managed across the organisation.

**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 Tayside should:

8 consistently use document control within all investigation documentation

9 develop and implement a system for capturing and sharing thematic learning from standard significant event analyses which do not progress to significant clinical event analysis, and

10 develop the Datix system to ensure review reports are attached to the incident report and allow central monitoring of actions.

**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 Tayside should:

11 provide guidance to ensure consistency in decision-making for undertaking (or not) a standard significant event analysis for amber incidents, clusters of green incidents or near misses.

**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 Tayside should:

12 continue to monitor and improve compliance with reporting, verification and review timelines, and

13 develop a mechanism to centrally monitor the implementation of action plans, capture lessons learnt and improvements that have been implemented that could be shared across the organisation.
We have asked the NHS board to develop an improvement plan to address the identified recommendations.

We would like to thank NHS Tayside and in particular all staff at Ninewells Hospital, Dundee, and the Carseview Centre, Dundee, 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 Tayside 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 52 recorded significant adverse events over the past 18 months, and
• details of four specific significant adverse event reviews.
1.1.8 Of the 52 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 Wednesday 17 July 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 Tayside’s chief executive on 5 August 2013.

**Improvement plan**

1.1.12 We expect NHS Tayside 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 Tayside 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.
NHS Tayside’s adverse event management policies and procedures

2.1.1 NHS Tayside is responsible for providing health services for around 400,000 people living in Tayside. The NHS board employs around 14,000 staff and provides primary, community-based and acute hospital services for the populations of Dundee City, Angus and Perth & Kinross.

2.1.2 NHS Tayside consists of Tayside NHS Board, the operational unit and three community health partnerships (CHPs) in Angus, Dundee and Perth & Kinross.

2.1.3 The operational unit comprises acute hospital services provided from Ninewells Hospital and Medical School, Perth Royal Infirmary, Stracathro Hospital, King’s Cross Hospital and Dundee Dental Hospital. It provides a wide range of community based services managed through the three CHPs. The operational unit also provides mental health services throughout Tayside, and is responsible for Armitstead Child Development Centre.

Policy for managing adverse events

2.1.4 NHS Tayside reported that it had recognised there was scope for improvement in its previous adverse incident management policy. As a result, the NHS board reviewed its whole system and policy. The revised policy is called the significant event management policy (hereafter referred to as the policy). The NHS board’s executive team endorsed an implementation plan for the policy, which was approved by NHS Tayside’s Board on 23 August 2012. As part of the launch of the policy, the implementation plan was presented at a number of the organisation’s standing committees as well as being discussed in detail by safety, clinical governance and risk groups.

2.1.5 The policy provides guidance to staff on how to report and respond to all accidents, incidents and near misses which either caused or could have caused injury to individuals or damage or loss to NHS Tayside property. The policy includes guidance on:

- how to carry out a standard significant event analysis (SSEA)
- how to carry out a significant clinical event analysis (SCEA)
- information specific to particular types of incidents
- communicating with patients
- external enquiries
- release of incident report forms and significant event analysis reports, and
- guidance on support and feedback for staff.

Adverse event definitions

2.1.6 NHS Tayside defines an incident as all incidents, near misses, events or circumstances arising during NHS service provision that could have, or did, lead to unexpected harm, loss or damage.

2.1.7 SCEAs focus on significant clinical incidents which have an impact of permanent psychological and/or physical harm or death of one or many patients. A SCEA must be held for:
• all suicides of patients currently receiving a mental health service or having done so within 12 months before their death
• wrong site surgery
• retained instrument after an operation
• any medication incident which causes death
• misplaced naso or orogastric tube not detected prior to use
• missing patient
• maternal death
• unexpected still birth
• intravenous administration of mis-selected concentrated potassium chloride
• inadvertent intrathecal administration of parenteral medications
• serious assault of staff and/or patients
• breach of any policy or procedure resulting in harm (actual or potential) to patients, staff or the organisation
• ward closure
• healthcare associated infection (HAI) death
• any hospital/healthcare acquired notifiable infection
• death in custody
• any drug related death
• child/adult protection incidents, and
• an IT failure or other external event that impacts on service delivery.

2.1.8 The policy also states that local teams can also request a SCEA in the following circumstances:

• where the incident is likely to result in highly damaging adverse publicity/defamation
• where the incident is likely to result in a claim being pursued against the organisation
• where the incident could result in any of NHS Tayside’s hospitals being incapable of operating normally and whereby “shut down” is imminent, and
• where there is system-wide learning to improve care.

2.1.9 Following a description of the incidents for which a SCEA should be carried out, the policy states:

“Standard significant event analysis or Local Reviews must be held for all other red incidents and if local teams feel appropriate for amber incidents and clusters of green incidents. They should also be held for all unexpected deaths in hospital.”

2.1.10 In the same section, the policy states that the SSEA should be Chaired/facilitated locally within the directorate, where possible. It states that the SSEA should be held
within 28 days of the incident. The draft report produced by the SSEA should be issued confidentially to all attendees for amendments or approval, and again in its final form.

2.1.11 Appendix 1 of the policy clarifies that incidents featuring on the list for SCEA should have an SSEA carried out within 7 days. According to this appendix, red incidents not featuring on the list for SCEA should have a SSEA carried out within 28 days, as should amber incidents where this is considered appropriate.

2.1.12 The policy requires the incident severity to be graded based on the harm caused, where 1 = negligible and 5 = catastrophic. The likelihood of recurrence is also graded from 1 = remote to 5 = almost certain. Following this assessment, these gradings are combined in order to determine the potential risk exposure rating. The policy notes that:

“The level of significant event analysis required for actual events should not be solely dependent upon the incident grading but must include consideration of the potential risk exposure rating for both incidents and near misses.”

2.1.13 In addition to the guidance in the policy on grading incidents, NHS Tayside has produced a traffic light guide for staff to help them recognise the types of incidents which should be recorded as red, amber and green. The guide is more recent than the policy, dated 1 April 2013. The guide states that it should be used with some discretion. Staff noted that cases could be regraded if they were felt to have been recorded incorrectly.

2.1.14 The list of red incidents from the guide is similar to the list for which SCEA must be carried out. It includes:

- wrong site surgery
- retained instrument post operation
- wrong route administration of chemotherapy
- misplaced naso or orogastric tube
- missing patient
- maternal death/healthcare associated infection (HAI) death/drug related death/death in custody
- unexpected still birth
- suicide
- escape from medium/high mental health facility by transferred prisoner
- child protection incident
- IV administration of mis-selected concentrated potassium chloride
- medication incident resulting in death, and
- attempted suicide.

2.1.15 The guide’s list of amber incidents includes violent incidents and ward closure, which also feature on the list for SCEA.

2.1.16 NHS Tayside has identified the top nine themes for significant adverse events as:
- failure to recognise the deteriorating patient and take appropriate action
- failure to escalate to senior personnel in a timely manner
- incomplete/inadequate record-keeping
- the need to work in a multi-professional manner and use the skills of the wider multidisciplinary team when indicated
- communication in the interface between and across disciplines and services
- communication
- lack of proactive follow-up of patients who do not attend or fail to engage with the service
- informed consent issues, and
- interpretation of radiological images.

**Governance arrangements**

2.1.17 NHS Tayside advised that performance and learning from adverse event management is considered by the following committees and team meetings throughout NHS Tayside as outlined in Figure 1 on page 14.

- NHS Tayside’s Board ultimately approves the adverse incident management policy and also receives assurance and minutes from the improvement and quality committee and the audit committee.
- The audit committee is responsible for reviewing the systems and processes in place for risk management, including incident management. It receives mid-year and annual risk management reports.
- The improvement and quality committee receives assurance from the clinical quality forum through the provision of an annual committee report and minutes.
- The clinical quality forum manages clinical governance and quality activities within NHS Tayside. It meets every 2 months and receives reports from each directorate/CHP, including a scorecard detailing performance on incident management and other indicators. The NHS board advised that there were plans for the clinical quality forum to review all SCEAs on a quarterly basis.
- NHS Tayside advised that a copy of every completed SCEA report is sent to the chair of the local service quality forum to ensure evidence of monitoring and completion of the action plans. Local quality forums and safety, governance and risk groups provide regular reports to the NHS Tayside quality forum on progress against actions, and escalate any issues which are identified.
- Each directorate/CHP has a safety, governance and risk meeting which discusses adverse events, improvements and learning. These normally meet every month. The policy states that line managers are responsible for monitoring follow-up reports to this group from all red incidents and any amber incidents requiring remedial action.
- The weekly executive management team meeting is attended by the head of clinical governance and risk management. The team receives weekly verbal updates on SCEA and red events.
- Clinical risk management meetings are held every week with the nurse director and medical director. The agenda covers updates on individual SCEA cases and any potential new and emerging cases for consideration.

- The clinical governance and risk management team communicates details of red events on the Datix system to the chief executive, deputy chief executive, chief operating officer, nurse director, medical director, the appropriate general managers and the head of clinical governance and risk management every day.

2.1.18 Figure 1 outlines these governance arrangements in place for the management of adverse events. Local management teams also monitor green incidents for trends and clusters.

**Figure 1: NHS Tayside’s safety, clinical governance and risk reporting structure**

![Diagram of NHS Tayside’s safety, clinical governance and risk reporting 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 NHS Tayside’s policy states that incidents involving a patient should be noted in the patient’s case record. It also states:

“A full, frank and factual explanation must be shared with the patient at the time of the incident. This should be done by a team of at least 2 staff members including a clinician who has a pre-established relationship with them with a clear team leader identified. State what happened, why it happened and what is being done to prevent it from happening again (IHI, 2010). Address any concerns the patient and/or family have as soon as possible. This team should inform the patient and family as soon as the organisation has any new information pertaining to the event.”

3.1.2 The policy includes examples of essential messages and words of compassion, concern, empathy and remorse for staff to use in their communications.

3.1.3 The policy states that relatives must be given the opportunity to contribute to the SCEA. The form of contact may depend on the circumstances and the policy suggests that the chair (usually nurse or medical director) should consider meeting with the family, supported by the appropriate service manager or clinician. Even if such a meeting takes place, families who have indicated they wish to be involved in the review must receive a letter from the chair, summarising the learning from the review and advising them of who they can approach if dissatisfied. The NHS board also advised that a copy of the SCEA report is provided to the patient or their family, without being redacted.

3.1.4 In the cases we reviewed, we found evidence of a systematic, well-documented approach to involving patients, families and carers in the review process. Staff used a form to record contact and communications with the patient and family in relation to the SCEA. Although the family had not been informed that an adverse incident had occurred in one of the four cases we reviewed, the reason why this decision was made was documented.

3.1.5 We also found evidence that NHS Tayside is continuing to develop its approach to involving patients and their families. The process has been refined and adapted based on patient and staff experience. For example, patients and their families are asked if they have any questions about the adverse incident before the review. NHS Tayside staff noted that the issues raised could be unexpected, and highlighted that it was important not to assume what would be important to the patient and their family. Meetings are held to provide feedback to patients and their families following the SCEA. These are used to address any questions previously raised by the patient and their family, and on occasion the family have further questions in response. The NHS board emphasised the
importance of maintaining a dialogue with patients and their families until all involved are satisfied with the way in which the incident has been addressed.

3.1.6 NHS Tayside advised that it had recently begun to seek consent from patients and their families to share anonymised details of adverse events more widely amongst NHS Tayside staff to better learn from these. The NHS board recognises there are wider opportunities to learn from specific adverse events and is actively looking at alternative mechanisms.

3.1.7 NHS Tayside provided the review team with a draft copy of a SCEA leaflet which the NHS board was developing to support patients and families involved in this process. This was being consulted on and was not yet in use.

Staff involvement

3.1.8 The policy notes that NHS Tayside has a duty of care to all employees when a critical incident occurs in the workplace. It advises managers to refer to and follow the NHS Tayside critical incident employee support policy. Managers are also advised to establish contact with the employee director’s office to ensure staff side representatives can be alerted to actively provide support. The policy also advises that the occupational health and safety advisory service and the department of spiritual care are available to support staff following an adverse incident. The NHS board has a chaplain who works solely to support staff.

3.1.9 The NHS board reported that the majority of staff have now received training in the new Datix incident reporting system and have access to report an incident. Staff spoken with during the visit reported that they were confident about reporting incidents and did so regularly.

3.1.10 However, some staff stated that they receive no feedback when they report an incident. These staff members were aware that it would be reviewed at some point by a manager, but received no information on this, or any actions taken as a result of their initial incident report. NHS Tayside recognises this as a weakness and intends to develop the feedback mechanisms within Datix to address this.

3.1.11 The policy states that staff who are involved in an adverse event should be involved in the SSEA and any SCEA which is carried out. Following each type of review, a confidential draft report is issued to all attendees for amendments and approval. Once agreed, SCEA reports are forwarded to relevant committees for follow-up and completion of action points.

3.1.12 The policy notes that feedback to frontline staff is a key element of the NHS board’s incident reporting mechanism and states that all clinical groups have a safety, clinical governance and risk management structure which should be used as a forum for discussing adverse events, sharing learning and follow-up of actions and changes in practice.

3.1.13 In the cases we reviewed, we found evidence of a systematic approach to involving staff which has been developed and improved over time. The approach to staff engagement and involvement aims to be as inclusive of all staff who have been involved in the incident as possible.
3.1.14 Staff involved in one of the earlier cases we reviewed stated that they had not been aware of what to expect before the review took place. In response to this feedback, NHS Tayside produced a frequently asked questions leaflet for staff. This leaflet is now provided to all staff involved in SCEA, before the review takes place. It includes information about the process, but also contains contacts for support through chaplaincy services and the occupational health and safety advisory service. The leaflet has also been used in the raising awareness sessions which NHS Tayside held to improve staff understanding of the incident management process.

3.1.15 In one of the four cases we reviewed, the draft SCEA report was shared with staff involved in the incident by their manager. Staff were given the opportunity to comment on the report in discussion with their manager, but were not given a copy of the report until the final draft was approved. NHS Tayside advised that this was due to particular sensitivities around that case. However, managers advised that the NHS board had learned from experience in the 19 months since that case. They reflected that the NHS board would now give each member of staff involved in the incident their own copy of the draft report for comment/approval.

3.1.16 In the other three cases we reviewed, staff were provided with copies of the draft report when it was produced and given the opportunity to comment on the accuracy of the report. Staff also reported receiving a copy of the final report and action plan.

3.1.17 Due to concerns about data protection, NHS Tayside reported that they are reluctant to share SCEA reports with members of staff who were not involved in the incident and review. Action plans, lessons and themes were reportedly shared more widely. As noted above, NHS Tayside has recently begun to seek consent from patients and their families to share anonymised details of adverse events more widely within the NHS board. The NHS board is also looking at other mechanisms to share learning.

**Recommendations**

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

1. finalising the draft patient/family information leaflets and demonstrating that these are used consistently
2. continuing to implement the planned changes to the NHS board’s new Datix system to ensure staff involved in incidents have access to timely feedback, and
3. agreeing the approach to sharing more detailed review reports, learning and actions across the organisation.
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 policy states that staff should report incidents using the electronic incident reporting system, as directed by the training manuals, as soon as possible when an incident occurs, and within 24 hours.

3.2.2 NHS Tayside recently changed their system for reporting adverse events. Until 31 March 2013 staff used a web-based electronic incident reporting system called AIM. Staff now report incidents using the Datix system.

3.2.3 NHS Tayside advised that the majority of staff have been trained on Datix and are able to access training on how to report incidents through a LearnPro module. Training has also been carried out through a series of roadshows, which have been videoed and are available for staff to view on NHS Tayside’s intranet.

3.2.4 NHS Tayside noted incident reporting and awareness of adverse incidents has increased since the new system was introduced. Staff find reporting through Datix straightforward and easy to navigate. However, feedback from staff also suggests Datix is less functional in certain areas than AIM. Work is under way to develop the system to address these concerns.

3.2.5 Guidance on grading and risk matrices is provided in the policy. This is described in more detail in Section 3.5. The verifier has responsibility for reviewing and ensuring accurate gradings are applied. The policy also includes information on using several facilitation tools and the National Patient Safety Agency’s incident decision tree to manage and review adverse events.

3.2.6 NHS Tayside recognised the need to improve existing staff training arrangements and a training needs analysis was undertaken to identify the requirements of verifiers, practitioners (those involved in reviews) and experts (in investigation techniques/methodology) within the organisation.

3.2.7 There are 850 staff who verify incidents on Datix and the NHS board noted the importance of supporting these staff to recognise the potential significance of near miss incidents. Risk aware workshops are being rolled out and shadowing opportunities offered to enhance their skillset. At the time of our review, the mental health team was testing a process and the NHS board had developed an implementation plan to spread the learning to other clinical areas.

3.2.8 NHS Tayside has 14 members of staff with expert training in root cause analysis and investigation techniques. The NHS board identified a need for this to increase to around 40 people and is exploring ways to cascade appropriate training and support. NHS Tayside noted that having a pool of 40–50 individuals trained in investigation methods would ensure SEA reviews carried out at a local level were more robust, which would in turn support a decrease in SCEA requests.
3.2.9 NHS Tayside advised us that it planned to have local reviewers trained using the Healthcare Improvement Scotland online training resource which was being developed for suicide reviewers as soon as it was available. It was hoped this would ensure consistency and quality of approach to SSEAs.

3.2.10 During our visit, staff advised that the previous AIM system had included templates which were used to support SSEA, which they found to be helpful in conducting investigations. Although these templates are no longer accessible through the new Datix system, they are still available as an appendix in the policy and some of the SSEA template fields are included in the Datix forms. NHS Tayside advised that a phased approach was being taken to developing the Datix system and further changes would be made to improve functionality. It was noted that ensuring staff implement a standard approach for SSEA investigations would allow the NHS board to better support staff carrying out local reviews. Promoting the use of standard checklists and templates should help to ensure consistency across NHS Tayside.

3.2.11 The NHS board also advised that a number of tools are available on the clinical governance and risk management website:

- DVD of the roadshows
- Quick guide to adverse events
- Adverse event process flowchart
- Guidance and direction for grading events
- Notes for chairing reviews
- Core questions for standard and significant reviews.

3.2.12 During the review, staff told us that the clinical governance and risk management team provides advice and guidance to support staff in the incident reporting and review process. A clinical governance and risk management co-ordinator is allocated to each directorate to facilitate the process and ensures consistency in approach.

**Recommendations**

To support staff knowledge and training, NHS Tayside should:

4. carry out the actions identified in its implementation plan to improve training of incident verifiers and reviewers, and

5. ensure staff have a clear understanding of investigation techniques/methodology to support consistency in incident reviews and action planning, and are able to implement a standard approach for standard significant event analysis investigations, including the use of templates.
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 sets out staff responsibilities and accountability when an incident is identified. All staff are accountable for following the procedures outlined in the policy. However, responsibility for managing the process lies with local management teams.

3.3.2 The NHS board’s current process for managing adverse events is outlined in Figure 2 on page 20. The member of staff who identifies the incident must complete the electronic incident reporting form as soon as possible, and within 24 hours. It is their line manager’s responsibility to verify incidents within 72 hours of receipt, manage and report the adverse event in accordance with the grade and type of incident or near miss.

3.3.3 Staff spoken with during the review reported that they were aware of their own role in terms of reporting incidents.

3.3.4 The Datix system immediately alerts senior managers by an automatic system generated email when a category red incident is recorded. Executives are also alerted through a daily red incidents report. The person reporting the incident must also select the appropriate line manager to verify the incident and the line manager also receives an email to notify them of the incident. If they are absent, senior managers are aware of the need to forward category red incidents to another manager. However, amber and green category incidents which are not verified on time will only be identified through reports when they become overdue.

3.3.5 The policy states that if one of the events featuring on the list for SCEA occurs, staff must notify the general manager, head of nursing or clinical service manager within an hour, before reporting the incident. The head of nursing or clinical service manager informs the relevant executive director within an hour, undertakes an assessment and analysis, and provides the executive director and general manager with an initial explanation of the incident within 24 hours.

3.3.6 The policy states that the line manager or their deputy must carry out a SSEA within 28 days of a category red incident taking place, or within 7 days of an incident featuring on the list for SCEA. SSEAs are also carried out for amber incidents and clusters of green incidents.

3.3.7 The policy states that, if a SCEA was considered to be appropriate, the SCEA team should include:

- nurse director (or nominated deputy)
- medical director (or nominated deputy)
- associate medical director for the service
- relevant head of service/service manager
- head of clinical governance and risk management
- patient/public representative, and
- other staff appropriate to the incident.

Figure 2: Adverse Events Flowchart

3.3.8 The policy notes that other staff appropriate to the incident could include relevant mental health staff, primary care staff, general hospital staff, police, local authority,
voluntary sector staff, prison healthcare staff and Scottish prison service operational staff.

3.3.9 The policy states that the SCEA review is chaired by either the nurse director or medical director. These individuals are considered to have the appropriate independence, organisational authority, skills and knowledge to carry out an effective review. The NHS board has produced a set of core questions which should be asked at every SCEA. Standard questions cover patient and family involvement, staff involvement, chronology of events, improvements and dissemination of learning, care delivery problems, use of safety tools, identification of contributory factors and recommended actions.

3.3.10 The chair can be supported by other relevant experienced staff who are independent from the service for which the SCEA is being carried out. The policy states that the chair should consider how relatives should be given the opportunity to contribute to and receive feedback following the review.

3.3.11 The SCEA process is managed by a member of safety, governance and risk administration staff, who is responsible for ensuring that all necessary information is available to the review team in advance of the meeting. This individual is also responsible for recording the SCEA. To support this process, the NHS board has produced templates which are completed when a review is requested, and to record its findings.

3.3.12 Staff spoken with were clear on their role as part of the review team and were aware of the guidance and support available to them if required.

3.3.13 A copy of every completed SCEA report is sent to the chair of the local service quality forum to ensure monitoring and completion of the associated action plan. Information on significant adverse events is also included in the key performance indicator information reported to the local clinical governance group.

3.3.14 NHS Tayside advised that local quality forums and safety, governance and risk groups provide regular reports to the NHS Tayside quality forum on progress against actions and could also escalate any issues which had been identified. We saw examples of evidence of this from two directorate clinical governance groups.

3.3.15 The clinical quality forum receives reports from each directorate/CHP, including a scorecard detailing performance on incident management and other indicators. It was noted that this forum is not currently presented with the detail from the reviews, but monitors the process and resulting actions. The NHS board advised that the clinical quality forum will now review all SCEAs on a quarterly basis.

3.3.16 The improvement and quality committee (chaired by a non-executive director) receives assurance from the clinical quality forum through the provision of an annual committee report and minutes.

3.3.17 All cases reviewed provided evidence of adverse events being reported, discussed or monitored by the appropriate governance group/forum.
Recommendations
To ensure clear functions and roles, NHS Tayside should:

6 clarify the role of the clinical quality forum in reviewing significant clinical event analyses, and
7 evidence adverse event information being fully reported and discussed at governance meetings to support clear oversight of how adverse events are managed across the organisation.

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 Tayside’s policy states that the electronic incident reporting system must be used to record all accidents, incidents and near misses which either caused, or could have caused, injury to individuals or damage or loss to NHS Tayside’s property.

3.4.2 The policy outlines the minimum dataset which must be collected and provides guidance on additional reporting and recording requirements for reporting of injuries, diseases and dangerous occurrences regulations (RIDDOR), child protection incidents and prisoner healthcare incidents.

3.4.3 The policy states that the line manager of the person reporting an incident verifies the incident. For category red incidents, the line manager also completes the executive summary of a red incident template included in the policy. If required, they manage the SSEA process. The policy states that this includes completing a SSEA report template, which is included in the policy as an appendix. Staff we spoke with during our review suggested this had become more challenging with the introduction of the Datix system, which did not include an equivalent template.

3.4.4 Managers must escalate all category red incidents to the executive team within 24 hours of verification. A template for this is included in the policy as an appendix.

3.4.5 The general manager, clinical manager or head of service is responsible for requesting a SCEA by completing the request form, also included as an appendix in the policy.

3.4.6 Clinical governance and risk management administration staff manage the SCEA process ensuring all relevant information and documentation is available to the review team. A checklist of standard documentation for a review is provided as an appendix to the policy. The NHS board also has a standard operating procedure in place for communications with patients and families, including a template for recording all discussions.

3.4.7 A template (included in the policy as an appendix) is used by clinical governance and risk management staff to record the review. It includes membership of the review team, methodology used, summary, findings, conclusion, and actions. It incorporates an action tracker template to record actions, responsible officer, review date, measures of
implementation, measures of effectiveness, position to date and status. Staff are prompted to include the review report form and local incident review as appendices.

3.4.8 The documentation provided for the four cases reviewed demonstrated consistent use of the templates for recording and reporting throughout the review process and for communicating with patients/families/carers. Case documentation also demonstrated the use of a central repository for case information with version control present in the file naming convention.

3.4.9 Staff advised that it was possible to store documents related to each incident in Datix as part of the case record. Some areas were using this, which allowed staff easy access to relevant documents. However, use of this facility had not been rolled out as part of NHS Tayside’s policy. The NHS board recognised the importance of ensuring this was used in a standardised way.

3.4.10 Actions are currently tracked through local governance structures with support from the risk management team. The NHS board identified that improvements will be made to Datix to allow more robust central tracking of actions. The NHS board reported that it intends to ensure all SCEA reports are appended to the original incident recorded within Datix once signed off by the nurse director and medical director. The Datix incident record would also be linked to any related complaints or claims.

3.4.11 NHS Tayside advised us before our review visit that its previous electronic incident reporting system provided an audit trail from the incident occurring to making recommendations for improvement, but did not record evidence of change and improvement. However, the NHS board advised that this will be addressed through the move to the Datix system, which has the ability to include similar functionality.

3.4.12 We found evidence that NHS Tayside has a document control process in place to track comments made on draft SCEA reports, including when the comment was made, who made the comment and the resulting changes made to the next version of the report. A standardised approach to document control was not evident within the case information reviewed in the four cases.

3.4.13 NHS Tayside advised us before our visit that it had identified a number of further improvements. Work is under way with the corporate web management team to store and manage both archived and active SCEA documentation within NHS Tayside’s electronic document store. At the time of our visit, the work had been approved and the NHS board advised that it was investigating how this could work with the recently implemented Datix system.

3.4.14 The NHS board is also developing processes within local clinical governance groups to ensure that actions are robustly monitored and improvements implemented. At the time of our review, this was being tested in mental health.

3.4.15 The review team noted that NHS Tayside should consider the approach for managing SSEA reports and learning, particularly for incidents which did not progress to SCEA. The NHS board should ensure robust management of all SSEA documents in order to monitor learning from these reviews. It should also develop and implement a system for capturing and sharing thematic learning from SSEAs which do not progress to SCEA. NHS Tayside advised of its intention to increase the cohort of staff trained as investigators to support more robust local reviews.
To support its information management processes, NHS Tayside should:

8 consistently use document control within all investigation documentation

9 develop and implement a system for capturing and sharing thematic learning from standard significant event analyses which do not progress to significant clinical event analysis, and

10 develop the Datix system to ensure review reports are attached to the incident report and allow central monitoring of actions.

### 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 policy states that when an incident occurs, staff should record it on the electronic incident reporting system. The policy is due to be updated in August 2013, when changes will be made to reflect the move to the Datix system.

3.5.2 The policy states that the following will be recorded as a minimum dataset:

- “What happened? Near miss or actual incident?
- Consequence calculation. (What is the impact of this incident? Red, Amber or Green? This is the actual consequences and not the potential consequences. This grade will give guidance regarding reporting arrangements. The Red, Amber and Green selection will enable forward reporting.)
- Location
- How it happened. Immediate or proximal causes
- Why did it happen (if known)? Underlying causes
- What action was taken/proposed? Immediate and longer term
- What impact did the incident have? (Harm to the organisation, the patients/others)
- What factors did or could have minimised the event?
- Is this event likely to recur? (Red, Amber or Green risk based on potential likelihood x potential consequences).”

3.5.3 All four cases we reviewed were logged on the electronic incident reporting system using the IR1 form. One case included two incidents which were recorded on separate IR1 forms. These forms included most of the information described above. However, there was no record in any of the four cases of the initial report recording factors which could have minimised the event.

3.5.4 In the case which involved two incidents, the second IR1 form noted that a SSEA had already been organised and would take place 5 days after the second incident was
recorded. Although there is no record of this decision being made, both incidents were graded as red impact with amber recurrence. The second incident also featured on the list for which SCEA would be automatically required. As such, holding the SSEA within 7 days of the incident being recorded would be expected. However, the incident report was not verified until almost 2 months after the incident was reported, considerably after the SSEA took place.

**Escalation of events**

3.5.5 The policy includes information on how the risk matrices should be used to establish the consequence and likelihood score, and potential risk exposure rating to give the grade of an incident.

3.5.6 Once the reporter grades the incident in terms of likelihood and consequences to produce a red, amber or green score, a gate-keeping mechanism then exists through the verification process. Line managers double check the scores and the information provided. If there is insufficient information, the line manager can reject the incident and ask for it to be resubmitted with additional information. The line manager can also re-grade the incident if this is considered appropriate. Staff we spoke with during our review confirmed that this happened.

3.5.7 As outlined above, the escalation of an incident is dependent on the severity rating. Line managers are expected to verify the electronic incident report form within 72 hours. The policy states that line managers must escalate all incidents verified as having a red initial impact to the appropriate member of the executive team within 24 hours of verification by completing an executive summary of a red event. A template for this form is provided in the policy. Managers can also escalate any other incident they feel is appropriate to the attention of the executive team at the time it occurs.

3.5.8 Three of the five incidents we reviewed were graded as having either a red impact or recurrence. Executive summaries were completed for all three incidents. One was recorded as being sent within 24 hours of verification as stated in the policy. One was sent prior to verification, 5 days after the incident, as verification took longer than the expected 3 days. The third executive summary was sent 11 days after verification.

3.5.9 The policy contains a list of actions to be completed when a category red incident occurs during normal working hours. The general manager, head of nursing or clinical service manager should inform the appropriate executive director(s) within an hour, conduct an initial investigation and analysis, and provide the executive director with a provisional explanation within 24 hours of the incident. The general manager, head of nursing or clinical service manager is responsible for providing additional reports to the executive director or executive team if requested where the incident requires a greater degree of urgency.

3.5.10 If an incident features on the list for a SCEA, the person reporting the incident must contact the general manager, head of nursing or clinical service manager as soon as they become aware of the event. They must then record the incident on the electronic incident reporting system as soon as possible and within 24 hours. The incident is then submitted to their line manager or line manager’s deputy for verification. In addition, if a category red incident occurs out of hours, the line manager of the person reporting the incident should notify the on-call executive director(s) immediately, and within one hour. We did not find evidence to record this happening consistently in the cases we reviewed, which took place before the introduction of the Datix system. Staff advised
that the Datix system issues an email to the relevant line manager and senior staff when a red incident is recorded.

3.5.11 The policy states that if a SSEA is to be carried out, the report template included as an appendix in the policy should be completed within 28 days. A SSEA should be completed within 7 days if it is anticipated that it will be followed by a SCEA. If a SCEA is required, this should be requested by the head of nursing or clinical service manager. The SCEA team decides if the review will go ahead. There was evidence in three of the four cases that we reviewed that this had happened through completion of a template SCEA review request form. This includes:

- patient details
- a brief description of the incident
- the date of the local review, which should be attached
- information on the member of staff requesting the SCEA
- date of the SCEA request
- details of whether the SCEA is agreed, or why not
- panel members
- details of contact with the family
- a list of key personnel to attend the review
- contact details for the patient’s GP
- a list of documents required prior to the review, the individuals responsible for supplying these documents and the date by which they are needed.

3.5.12 The fourth case was the oldest of the cases we reviewed. It did not include a SCEA review request form. Instead, a list of key information was provided. This included some of the information included on the SCEA request form, namely:

- patient details
- a list of key personnel to attend the review, and
- a list of documents required before the review including the local incident review report, the date by which these should be supplied and notes on who to contact if these were not already available.

3.5.13 Although there was no record in the fourth case of the decision to proceed to SCEA, the case involved an incident from the list specified in the policy as requiring SCEA.

3.5.14 For category amber incidents, the policy states that the line manager or their deputy should instigate and manage SSEA, where appropriate, and complete the report template within 28 days. The policy does not include any advice on how to determine whether significant event analysis would or would not be appropriate. There was no record of the decision making process in the cases we reviewed. However, the cases we reviewed all featured on the list of incidents requiring SCEA.

3.5.15 If remedial action is required from a SSEA, the line manager should forward the follow-up report to the specialty and directorate safety, governance and risk forum for
discussion, learning, monitoring and follow-up. We saw examples of this for two local forums. The policy states that category green incidents are managed and monitored locally. We did not see evidence of committee overview of these incidents.

3.5.16 The policy states that near misses will always be graded as category green and that trends and clusters of category green incidents/near misses may require a more in-depth review and that monitoring of green incidents for trends and clusters should be carried out by the local management team. Staff noted that one of the cases we reviewed which was graded as having category green impact and amber recurrence had a SCEA carried out due to occurring shortly after another similar incident.

3.5.17 Senior management reported that a weekly meeting is held to discuss all red incidents, review their status and, if appropriate, recommend they are progressed to a SCEA. SCEA request forms recorded senior managers’ decision to proceed with SCEA in three of the four cases we reviewed.

**Recommendation**

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

1. provide guidance to ensure consistency in decision-making for undertaking (or not) a standard significant event analysis for amber incidents, clusters of green incidents or near misses.

### 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 Investigation and reporting timelines are outlined in Figure 2 on page 20. The policy states that incidents should also be reported on the electronic incident management system as soon as possible after the event, and within 24 hours.

3.6.2 Two of the four cases we reviewed were reported on the electronic incident management system within 24 hours of their occurrence. One of these cases included two separate incidents which were both recorded within 24 hours of their occurrence.

3.6.3 Of the other cases, one incident graded as green impact and amber recurrence was recorded 2 days after it took place. The fourth incident was graded as amber impact and green recurrence. NHS Tayside became aware of the fourth incident through a complaint, which was received over 4 months after the incident occurred. However, the incident was not recorded on the electronic incident management system until almost a month after the complaint was received. There was a further delay of 3 days before it was submitted for verification.

3.6.4 The policy states that incidents recorded on the electronic incident management system should be verified by the reporter’s line manager within 72 hours of receipt. For category red incidents, the line manager should complete and send an executive
summary to the relevant members of the executive team within 24 hours of verification. They are also responsible for notifying the on-call executive director(s) if a category red incident occurs out of hours.

3.6.5 According to the policy, in normal working hours, following notification by the reporter, the general manager, head of nursing or clinical service manager informs the appropriate executive director(s) of the incident within an hour, conducts an initial assessment and analysis and provides this to the executive director within 24 hours of the incident.

3.6.6 The cases we reviewed had all taken place before the introduction of the Datix system on 1 April 2013. There was not always documented evidence in these cases to demonstrate that red incidents had been escalated immediately in accordance with the policy. However, staff advised that the new Datix system sends an email to the line manager selected by the person reporting the incident as soon as the incident is reported. This email also goes immediately to members of the executive team, who are alerted to incidents before verification by the line manager.

3.6.7 Of the four cases we reviewed (five incident reports), two incidents were verified within the specified time. Of the others, one was verified 5 days after the incident was submitted and noted that the executive summary was sent the same day; one took 18 days; and one took just under 2 months.

3.6.8 The policy states that where a SSEA is appropriate, this must be completed within 28 days. Where a SCEA is expected to follow this investigation, the SSEA should be completed within 7 days and must contain a recommendation to proceed to a SCEA.

3.6.9 For category amber incidents, the line manager or their deputy is expected to manage a SSEA where appropriate and the SSEA report should be completed within 28 days.

3.6.10 One of the cases we reviewed, which was graded as amber, recorded that no SSEA had been carried out as the incident was similar to another incident which had recently occurred. This incident predated the current policy. In another case, which was graded as red, the incident review took place 37 days after the incident was recorded. This incident also predated the policy. The other two cases had local reviews carried out within the specified timescale.

3.6.11 The policy states that where a SCEA is appropriate, it must be carried out within three months. In the cases we reviewed, it took between 2–4 months from the time the incident was recorded for the SCEA to be carried out. Two incidents were reviewed within 3 months of the incident taking place. Of the others, one incident was reviewed 3 months and 11 days after it occurred following a delay in carrying out the SSEA. No SSEA was carried out in the fourth incident, which may have contributed to the delay.

3.6.12 Our review found that at times there were delays between the incident occurring and the SCEA report being finalised. In the cases we reviewed, the process took between 2–10 months from the date of the SCEA review to the report being finalised. Overall, it took between 5–14 months from the time the incidents we reviewed were recorded for the SCEA report to be finalised. The NHS board acknowledged the time taken and noted that the end point is documented as once the final report is signed off by all involved in the review. The delay in final sign-off does not reflect a delay in the process in terms of identifying learning and implementing required improvements.
3.6.13 NHS Tayside has put in place targets for the reporting, verification and review of incidents and the management of SCEA. At the time of our review, data were being collated in line with the NHS board’s incident reporting measurement plan and SCEA measurement plan.

3.6.14 The incident reporting measurement plan measures in use by NHS Tayside are:

- % compliance with incidents fully completed and submitted within 24 hours on electronic incident reporting system
- % compliance with incidents verified within 72 hours of electronic receipt on electronic incident reporting system
- % compliance with incident review/SSEA completed on red event within 28 days of occurrence of the event
- % of unverified incidents on electronic incident reporting system
- % of red incidents reported on electronic incident reporting system
- % of amber incidents reported on electronic incident reporting system
- % of green incidents reported on electronic incident reporting system.

3.6.15 These measures do not appear to include the requirement to complete SSEA of all category red incidents within 7 days.

**Action planning**

3.6.16 The policy notes that formal recommendations for change from SSEAs must have action and monitoring plans so that the information is shared throughout the organisation. SSEAs are reported and monitored through local safety, governance and risk groups. We saw evidence from two local forums of SSEA reports being discussed at these meetings.

3.6.17 The policy states that a member of safety, governance and risk administration staff will record every SCEA using the template in Appendix 7 of the policy. This template includes an action plan and this is completed with all action points assigned an identified lead and a timeframe for completion. This had been used in all four cases we reviewed.

3.6.18 The policy notes that these action plans are sent to relevant directorate safety, governance and risk committees, who are responsible for ensuring the follow-up and completion of action points. We did not see evidence of discussion of these action plans by directorate safety, governance and risk committees. However, action plans for all four cases had been revised and updated with the majority of actions completed.

3.6.19 NHS Tayside advised that when a SCEA report is signed off, a copy of the report is sent to the chair of the local service quality forum to ensure evidence of monitoring and completion of action plans. The local quality forum in turn reports to the NHS Tayside clinical quality forum on progress against actions, and to escalate any identified issues. We did not find evidence of this happening for the cases we reviewed.

3.6.20 The NHS board reported that whilst action plans and improvements are monitored through local governance structures, there was not currently an organisation-wide overview of action plans, or a consistent approach to sharing actions or improvements outwith directorates.
3.6.21 NHS Tayside advised that its significant event management action plan existed to drive continuous improvement in the organisation’s approach to managing adverse events, including reporting, escalation, review and learning lessons.

Sharing of learning

3.6.22 The policy emphasises throughout that the purpose of both SSEA and SCEA is to identify and share learning, changes and improvements to systems and processes with other stakeholders. Templates for both SSEA and SCEA reviews include sections to identify lessons and outline how these will be shared. All clinical groups have safety, clinical governance and risk management structures which should be used to discuss adverse events, share learning and follow-up actions and changes in practice.

3.6.23 Due to concerns about data protection, NHS Tayside reported that it is reluctant to share SCEA reports with members of staff who were not involved in the incident and review. Action plans, lessons and themes were reportedly shared more widely. As noted above, NHS Tayside has recently begun to seek consent from patients and their families to share anonymised details of adverse events more widely within the NHS board. The NHS board is also looking at alternative approaches to sharing information.

3.6.24 The policy states that the reporter’s line manager or their deputy should forward follow-up reports from all red incidents to the specialty and directorate safety, governance and risk forum for discussing, learning and monitoring. They must also ensure a risk control plan is generated where appropriate. The line manager should also forward follow-up reports for amber incidents if remedial action is required following an investigation.

3.6.25 The policy notes that trend and clusters of green incidents or near misses may require a more in-depth review. It states that the local management team should monitor green incidents for trends and clusters.

3.6.26 NHS Tayside advised that it was testing the implementation of an approach used by the mental health scrutiny group, which invites services to provide evidence that completed actions from SCEA reports have led to improvement. If successful, this will become a whole system approach.

3.6.27 Staff spoken with reported that they were aware of learning being shared from incident reviews within their area, but not more widely across the organisation. Information is shared locally through service meetings and some staff spoke of the ‘Getting it Right’ newsletter. The NHS board recognised that developing mechanisms for sharing learning both within specialties and directorates, and more widely across the organisation, was an area that required development.

3.6.28 The policy also states that where families have indicated they want to be involved in the SCEA process they must receive a letter from the chair summarising the learning from the review, even if a meeting has already taken place. We did not see evidence that this happened consistently in the cases we reviewed.

3.6.29 NHS Tayside advised that it had been agreed that a review of all SCEAs would take place on a quarterly basis at the clinical quality forum. The NHS board also stated that significant clinical events now featured as a standing agenda item at each clinical quality forum meeting to raise awareness of numbers, locations, reasons for significant clinical events, trends and themes. We saw evidence that this had been put in place. Nursing
staff advised that learning from SCEA reviews was also shared verbally with colleagues during daily safety briefs.

3.6.30 NHS Tayside advised that discussions did not focus on the details of cases, due to concerns that individuals involved in incidents could be identified by this information. However, permission was now being sought from patients and their families to discuss cases in more detail in order to improve the spread of learning identified through significant adverse events.

3.6.31 Staff spoken with as part of the four cases reviewed reported that sharing of learning from their particular case had occurred both with staff involved in the incident, and across the wards or areas that they worked in.

**Recommendations**

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

12 continue to monitor and improve compliance with reporting, verification and review timelines, and

13 develop a mechanism to centrally monitor the implementation of action plans, capture lessons learnt and improvements implemented that could be shared across the organisation.
Appendix 1 – Details of review team

The review of NHS Tayside was conducted on Wednesday 17 July 2013.

Review team members

Mark Aggleton
Senior Programme Manager, Healthcare Improvement Scotland

Gordon Birnie
Medical Director, NHS Fife

Leanne Hamilton
Programme Manager, Healthcare Improvement Scotland

Tammy Nicol
Project Officer, Healthcare Improvement Scotland

Lorna Ramsay
Clinical Lead for eHealth, National Services Scotland

Susan Seigal
Public Partner

Lesley Anne Smith
Quality Improvement Programme Director, NHS Education for Scotland

Observed by:

Yvonne Bronsky
LSAMO South East and West of Scotland Region
We can also provide this information:

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