Annex D – Consultation response form

Respondent information

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Please return this form by 1 March 2013 to: hcis.adverseevents@nhs.net

Consultation questions

1	**What do you think should be included within the scope of the national approach?** ***Please see the attached response to this consultation***
2	**What principles should form the basis of the national approach?**
3	**How should adverse events be defined?**

4	**How should we categorise adverse events?**
5	**How should near-misses be reported and responded to?**
6	**How can we achieve consistency of approach for events that are assessed at the boundary between a significant adverse event and all other adverse events?**
7	**How could a nationally agreed list of significant adverse events add value?**
8	**How do we promote reporting and foster a 'just culture' across NHSScotland?**
9	**How can the national approach ensure that adverse events are responded to in a simple, proportionate and consistent manner across NHSScotland?**

10	**How do we ensure appropriate governance arrangements at a local level and how could this be supported nationally?**
11	**How do we embed a focus on involving patients and family in adverse event management?**
12	**Should patients and families be involved in the review of near-misses?**
13	**How do we involve and support staff in adverse event management?**
14	**How would analysis of national trends add value?**
15	**What mechanisms could be used to systematically share learning from adverse events across NHSScotland?**

16	**How can we measure if NHS boards, and NHSScotland, learn from adverse event reviews?**
17	**How should the national approach be aligned to other national safety programmes?**
18	**What impact would the application of a common definition of adverse events across NHSScotland have on NHS board systems?**
19	**How should implementation of the national approach be monitored?**
Any other comments	

Scottish Public Services Ombudsman
Response to
Consultation on building a national approach to learning from adverse events through reporting and review

I would like to thank Healthcare Improvement Scotland (HIS) for inviting me to respond to this consultation. It is an important initiative and one I fully support.

In deciding how best to contribute, I have decided not to respond to the individual questions set out. This is because I consider there are others best placed to provide the detail about how such a national approach should develop in practice. I am very aware of my position outside the system and, as shall be seen from my comments below, I consider that the best way to proceed is to allow the approach to develop as a strongly staff- and patient-led system and one, indeed, which is developed and created from the bottom-up rather than top-down. Instead of responding to the individual questions, therefore, I think it more helpful to HIS to explain our perspective and thereby explore how the development of this approach could help to create a culture of openness, transparency and candour within the NHS.

Our experience of adverse events reviews

Throughout the NHS there is currently a wide range of terminology around significant or adverse incidents. Many of the complaints I see involve claims of significant failings. However, what is striking is in how few cases any structured internal clinical review has occurred, apart from a consideration of the complaint. A properly conducted review which allows for open discussion and a systematic and holistic consideration of the incident has the opportunity to drive real improvements. These, however, rarely seem to happen in even the more serious cases which come to this office. It is extremely unusual for an organisation to initiate any sort of review when I am looking at a complaint, even though they know that I am investigating some significant issues and that the investigation may take some time.

The reviews I do see have often been limited by an overly-defined remit and a sense of working to the guidance or the procedure rather than working to the outcome. Staff become caught up in definitions and issues, such as who should be involved or who is allowed to know what is happening in a review, rather than seeing it as a procedure to improve patient care and a normal and regular part of good clinical practice. Too often, incident reviews feel like a paper exercise.

There is often confusion about how incident reviews relate to other processes, whether that is the complaints process or the work of other agencies. This leads in some cases to a complaints process being usedrather than a review conducted, or a review is made that looks at issues of significance to the organisation but does not answer the complaint made.

Of course it is important to point out that I have also seen examples of good practice where a review has correctly identified issues and put in place recommendations for improvement, which have already been implemented before the complaint reaches me. I consider that properly conducted reviews can be highly effective. They can provide direct benefits to the staff who are delivering the care, when those staff are

fully and directly involved in the reviews. Specifically, reviews can be particularly good at identifying causes and the sometimes complex web of causal interactions behind failings. This is why in some cases, despite my confidence that my own investigation has correctly identified the failings and the outcome of the failings, I have recommended that a review be undertaken. This is because there may still be lessons to be learned when staff are given the chance to directly explore the causes of those failings.

Considering the way forward

In the short term, some national guidance to help standardise the approach across Scotland would be undeniably helpful and a good first step. Looking forward, I think there needs to be a medium to longer term approach which looks at ensuring that reviews are not seen as something coming from outside the ward/GP practice. While they should seek to fulfil the needs of those responsible for governance it should primarily be a process which reflects the perspective and needs of those delivering and receiving care.

It is important that, at all times, the desired outcome, which is to ensure the highest possible quality of care at the point of delivery is the main driver of whether and how an incident review takes place.

The critical interface is the relationship between those delivering and those receiving care. This includes the family, friends and wider community of those who directly receive care.

It is fully accepted and not contested that events which are unexpected, and which lead to undesirable outcomes, should be explored in order to ensure lessons are learned, and that these lessons drive up quality. For this to occur, staff ownership of the process must come not only from staff responsible for governance, but from those delivering the care. Guidance can set minimum standards and provide some assistance to staff who may be unsure how to proceed. It can, however be counter-productive if it becomes seen as “someone else’s responsibility” or becomes used as a way of allowing staff to rule out issues which do not strictly fall within key definitions, or to focus on the process and not the outcome.

The benefit of a well-managed review process is its ability to take an objective and structured look at a specific incident. It provides a way of working out the causes that lie behind what went wrong or what nearly went wrong, and this in turn provides a way of improving patient care by tackling the causes. Any move towards a national approach should concentrate on ensuring that the benefits of the approach are fully understood and realised, and that the focus is squarely on the outcome.

Some practical steps

I would like to identify what I think may be the most critical steps to help fully realise the potential of a national system and to help support the cultural change to openness, transparency and candour.

Establishing the national approach

Some aspects will need to be common across all NHS organisations. This will help ensure not only consistency, but also facilitate sharing and learning from adverse events.

- *A common language that is easy to understand and share*
  There is a need to make sure that any national guidance is simple, straightforward and can be understood not only by those in the NHS but by the patient and the broader community. The language should be clear, simple and jargon-free. Examples of completed reports could be provided to show how to write these in simple language. It is our experience that if something cannot be explained simply, it has not been fully understood.

- *A common understanding of when a review is needed and the benefits it can bring.*
  There should be, from the start, case studies and examples that clearly show the benefits of the procedures and the outcomes sought. Examples are often more powerful than, and can support, key definitions.

- *Simple systems and definitions*
  Any system should seek to be as simple as possible and paperwork, jargon, and layers of bureaucracy reduced to an absolute minimum. There is often a direct relationship between simplicity and transparency. It is easier to be transparent when there are fewer layers. We also find that when a system is simpler, it is easier to focus on the substance, rather than the process. This is one of the reasons we have supported a move from complex complaints procedures to simpler ones across the public sector. Each involvement of additional personnel, forms to be completed or extra levels of approval to be given before release should be examined to check whether they are necessary for the outcome sought – the improvement of patient care.

  The need for simplicity should extend beyond the system for reviewing adverse events. The relationship to other processes and systems should be made clearer. To take a specific example, it should be clear when a complaint should trigger a review and also how to involve patients and their families and friends in a review process.

- *Sharing and learning*
  Reports of reviews should be prepared in a way that allows them to be shared easily and quickly. In the long term, I would encourage a move to a national database from which learning can be shared quickly and easily across the NHS. The database should be open and accessible. There may be a number of steps on the way towards developing such a system while issues are worked through, such as what information is useful and how to collate it as well as ensuring protection of sensitive data. The database may provide some early warning information of specific problems to regulators, but the focus should be on how useful the information is to clinical staff delivering care and to those receiving care. Such staff should be directly involved in creating and assessing the database.

- *The role of governance*

Leadership needs to come from within the NHS to emphasise the benefits of adverse events reviews and of openness, transparency and candour. A fear of negative publicity or litigation is sometimes seen or perceived as coming from the top of an organisation. The leadership role in terms of adverse events should centre around honesty and openness. This is an area where, when relevant, the Board should play a key role. They should have a clear view of the process and regard its success as a key indicator of the organisation's commitment to patient care. In smaller organisations, there could be a move to allowing groups of, for example, general practitioners or pharmacies, to work together and share learning from adverse events.

- *Establishing common standards*
  There should be a minimum number of these but they should be clear.

  I would suggest that, while there may be a need to create something quickly, frontline staff and patients should be directly involved in creating these standards and in establishing key definitions. For example, these groups could help identify types and categories of incidents that cause them concern and which they would expect or would like to see explored in more detail by a structured review process. Perhaps the national guidance could be a living document and subject to change in response to input from these groups. Frontline staff, patients and the wider community could also perhaps be directly involved in developing risk matrices and other tools.

  It would also be helpful to test any national standard against the understanding of these groups. Problems can be caused by, for example, differing views of what is meant by taking an 'objective' or 'independent' view. This can lead to concern about the definition and standard, which takes away from the quality of the review. Again, such definitions should always be tested against the outcome. What is often needed is openness and candour about what happened from inside the incident, with someone from outside it able to provide a balancing view of what should have happened. It is rare that someone completely independent, in the sense of outside the organisation itself, is involved. By working from the outcome and the understanding of those involved, however, definitions should be clearer and less open to misinterpretation. This should also help to identify those situations where a properly independent review is needed.

  Giving ownership to those delivering and receiving care for creating the definitions to drive the process, and ensuring that all information centrally gathered is based around their needs, should help encourage front-line staff to see themselves as responsible for process. It may also help reduce some of the fear and defensiveness that can occur when such reviews are underway.

  I would also suggest that the trigger for the process should not only be an adverse event but could also be incidents that staff consider could usefully benefit from a detailed review, or which are generating local concern for patients and their communities. The focus should not be on when an incident meets certain criteria, but rather when the approach of a structured review into an incident would bring benefits. Clearly there will always be incidents which by their very nature require a review. Starting from this slightly different viewpoint

could, however, encourage staff themselves to request and initiate a process on the basis of the benefit it could bring, rather than on the basis that there had been a specific failing or an incident of specific seriousness. This would help to make the review feel more like a normal part of clinical practice.

- *Involving the family/patient/wider community*
  The involvement of the patient and their family/friends is too often seen as an 'add-on' to a process. However, reviews are always about the care provided to one or more individuals. The comments and views of patients and family should be encouraged. This should extend not only to simply allowing them to explain their experience but to actively involving them in helping to identify the causes.

  In our experience, the key goal of most individuals who access the complaints process or raise concerns about an incident is to prevent a recurrence. However, at times, they can feel that, as a result of an investigation or review, something has been done about, or to them, rather than with them. There are many individuals and families in Scotland who have already gone through review processes and I would hope that you receive comments from them through this consultation. If that is not the case, I would recommend actively seeking their views on how they felt about the involvement they had and what they consider they could have offered to, as well as what they would have liked to have found out from, the process.

  The involvement of the individuals directly affected should not be seen as the end of the involvement of patients. As I have said above, I think the wider community has a supporting role to play in improving NHS care and there would be benefit to involving this wider community in both creating and developing the national standards and improving local processes and services.

In closing, I would like to again welcome this consultation as an opportunity to not only resolve real problems around the current handling of reviews, but to begin developing an approach which truly reflects the needs of those delivering and receiving care.