– Characteristics of successful reporting systems:
  • Reporting is safe for the individual who reports
  • Reporting leads to a constructive response
  • Expertise and adequate financial resources are available to allow for meaningful analysis of reports
  • The reporting system must be capable of disseminating information on hazards and recommendations for changes

Activity of the Group:
a) Undertook a literature review
b) Circulated to other sub groups a proposal for national monitoring and a spread sheet setting out potential measures, where they had been used or recommended elsewhere
c) Commissioned with the Scottish Patient Safety Programme a series of process mapping to consider the relationship between recording and learning from harms through the Scottish Patient Safety Programme and recording and learning from harms under the National Framework for Adverse Events.

a) Literature Review

From this literature review measures were set against the National Approach to Management of Adverse Events Driver Diagram. The measures related to overall aims and outcome as well as the deliverables against the working group areas. The measures were considered in relation to:
  • Description of measure
  • Reference – what document has recommended the measure
  • Where the measure has been used before
  • Is it a process or outcome measure
  • Does the measure support monitoring of implementation of the national approach or assurance
  • Is the measure applicable at a national and / or local level
  • Is there an existing data source
The group envisaged that to be effective a limited number of measures would be effective.

b) Proposal of data set and long list of measures
The Measurement Working Group outlined a potential data set whereby Boards would report nationally, a detailed data set on Category I incidents, and total numbers of Category II and III recorded (perhaps totals in specific categories?) and alongside this a long list of potential measure derived from the literature review. The Working Group recognised there should be a distribution of category 1, 2 and 3 adverse events – likely to look like a triangle.
Proposed Key Indicators for overall aims and outcomes for Scotland

- Total number of Category I events
- Percent of Category I events where a SAER was completed
- Percent of Category 1 events where a system cause was identified from the SAER
  - Percent of Category I events where improvement has resulted
- Percent of patients who felt that the event was discussed in a way they could understand
- Percent of patients who were satisfied with the way it was dealt with

The infrastructure group are working on defining the dataset. The measurement group recommend that as a minimum it should include information for each Category I event relating to:

- Service area / Specialty
- Incident type (see annex 1 for possible categorisations based on NPSA)
- Level of harm
- Information about the SAER (Patient involvement, Staff involvement and feedback to staff, amount of time taken...?)
- Result of root cause analysis (System causes, Individual error, ...?)
- Improvement actions resulting from the review
- Whether learning has been shared nationally

The long list of measures was distributed to the other subgroups for comment. This included measures against the overall aims and outcomes of the National Approach to Management of Adverse Events Driver Diagram.

**Core aim:** NHSScotland has a consistent national approach to learning from adverse events through reporting and review, which supports service improvements and enhances the safety of our healthcare system for everyone (to be achieved by 2015).

<table>
<thead>
<tr>
<th>Sub aims</th>
<th>Comments from other Sub Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHSScotland uses a common definition and categorisation of adverse events.</td>
<td>Will be a large piece of work</td>
</tr>
<tr>
<td></td>
<td>If there is data is entered in a national infrastructure then this will be a mandatory field and no measurement will be needed</td>
</tr>
<tr>
<td>NHSScotland reports a core dataset following an adverse event.</td>
<td>Agree proposal above</td>
</tr>
<tr>
<td>NHSScotland informs and involves patients and staff in adverse event reviews.</td>
<td>National patient experience survey is too blunt – needs to be generated at source</td>
</tr>
<tr>
<td></td>
<td>This is covered by the dataset for SAER (patient involvement, staff involvement and feedback etc)</td>
</tr>
<tr>
<td>NHSScotland captures consistent information in adverse events review reports and use a common approach to redaction.</td>
<td>If everyone trained in the same way there will be some consistency, therefore measures:</td>
</tr>
<tr>
<td></td>
<td>- No of staff completeing LearnPro / education packages</td>
</tr>
<tr>
<td></td>
<td>- No of staff trained in teachback</td>
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<tr>
<td></td>
<td>A qualitative approach to measurement is preferred – audit of review reports – consistent approach, common challenges and corrective / preventive actions.</td>
</tr>
<tr>
<td>NHSScotland actively shares learning from adverse events through contributing quality and timely information to a national learning system.</td>
<td>Qualitative approach more appropriate – regular reviews / audits of sample adverse events best way to assess quality and timeliness of info fed into national system</td>
</tr>
<tr>
<td>NHSScotland translates learning from adverse events to make service improvements.</td>
<td>Overall number of Category I events will be counted (should reduce over time).</td>
</tr>
</tbody>
</table>
The full list of measures and comments from sub groups is attached:

c) Process Mapping of Harms
During this literature review the overlap with the SPSP Harms was noted and, following a discussion with the Head of Safety in Healthcare Improvement Scotland, processing mapping events were held to consider the relationship between responding to significant adverse events and learning and improving in response to SPSP Harms (CAUTI, Pressure Ulcers, Cardiac Arrest, Falls, Paediatric, Primary Care, Maternity / Neonates and Mental Health). Outcome of mappings was not reviewed by the Measurement Working Group.

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