



The Scottish Parliament
Pàrlamaid na h-Alba

Health and Sport Committee
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Dear Mr Pearson

I refer to the evidence you gave to the Health and Sport Committee on Tuesday 28 November and as indicated by the Convener I have been requested to seek further information and elaboration in relation to aspects thereof.

The Official [Report](#) of the meeting is available here and for ease of reference I will refer to passages from it by reference to the relevant column numbers.

At column 3 you discussed the role of HIS in trying to create a framework to support the production of guidelines and standards. Could you provide more information here particularly on the timetable for this work and how the benefits might be identified.

You also posed the question of how the guidelines can be both relevant and implemented and your thoughts on how this work is to be progressed would be welcome.

At column 18 Brian Whittle asked a series of questions around serious adverse events (SAEs). The Committee is aware of the HIS National Framework and notes one of its aims as being to:

- “provide a consistent national approach to the identification, reporting and review of adverse events, and allow best practice to be actively promoted across Scotland.”

Notwithstanding the above, the Committee has heard evidence which suggests Health Boards, as we heard from Ayrshire and Arran this week, are able to determine for themselves what events require to be categorised as “adverse events” within the general framework.

Given the discretion we have heard about could you explain:

- how the Scottish Government can be assured that a similar event in each Board would all fall within the same category, i.e. an event that caused permanent harm, an event that had the potential to cause harm and near misses? and
- if there has been any assessment of how NHS Boards have implemented the HIS framework and the extent to which that resulted in a more consistent approach.

The Committee appreciates “the numbers are only part of the system” (column 20) but wonder - given there are issues with the consistency of reporting – if you could explain how it is possible to reliably identify “changes in patterns of incidents or concerns” occurring in an individual Board? (column 20).

The Committee has heard from both you and NHS Boards that data on serious adverse events is collected locally and that this is shared with the Scottish Government and HIS as part of the ‘performance management infrastructure’ for NHS Boards. However, in the meeting you did not seem enthusiastic about a national reporting system for SAEs. Can you explain in more detail your misgivings about adopting such an approach when the data is both collected locally and available to the centre?

Can you also provide greater detail on how the performance management infrastructure operates including details of the location of the information used for this monitoring? A worked through example with links to the locations of the information might be particularly useful here.

It is clear there may be a time-lag, perhaps of several months, between adverse events being reported and details appearing within the performance management infrastructure. During this period of time a series of similar events could and indeed have, in places, occurred. How does the current approach allow for the timely identification of similar incidents and avoid the build-up of systemic issues?

At last week’s session you also confirmed that some events are reportable to the Scottish Government (e.g. infections, stillbirths and people who have an instrument left in after surgery). We have also been told that HIS is informed of suicides in people who were in touch with mental health services 12 months prior to their death. Could you detail which events are reportable to the Scottish Government and/or Healthcare Improvement Scotland and in what timeframe they must be reported?

Beyond the National Framework is there any government guidance that has been issued about the need for scrutiny of SAE’s, the collection of the necessary information and its monitoring and if so could you submit a copy to the Committee.

HIS indicated (column 19) “there is an issue with the consistency and quality of reporting and with the quality of investigations.” It would also be helpful to understand what the issues referred to are in practice and the Committee would be interested to understand how those issues are being resolved to allow “the learning” to occur.

A further aim of the National Framework is to;

- provide national resources to develop the skills, culture and systems required to effectively learn from adverse events to improve services across Scotland.

The Committee is interested to understand how this is achieved under the current system. Please supply details of how national learning takes place using adverse events.

At column 21 the Committee was advised there are systems in place for learning from [complaints and adverse events]. It was further explained the Scottish Government monitors changes in the number of complaints and adverse events, along with HIS.

Given this ongoing monitoring by the Scottish Government could you provide detail of the number of adverse events reported by category and by Health Board in the last 3 years?

In concluding the meeting the Convener invited all witnesses to provide views on two issues; How to ensure all staff get the opportunity to keep their practice up to speed and undertake necessary CPD?; and how do we ensure dignity and respect are built into the healthcare system? The Committee would welcome your thoughts on both matters.

A response by Monday 18 December would be appreciated.

Yours sincerely

David Cullum
Clerk
Health and Sport Committee