Healthcare Improvement Scotland

Learning for improvement: report of the self-evaluation by NHS boards on the implementation of the adverse events framework

July 2026

NHS SCOTLAND

Contents

Foreword

The National Framework for Reviewing and Learning from Adverse Events sets out a consistent, Scotland-wide approach to the review of adverse events, with the aim of strengthening learning, improving patient safety and reducing recurrence. It is designed to support NHS boards to implement structured, proportionate and person-centred review processes, and to ensure appropriate clinical and care governance.

This report provides a national overview of the implementation of the National Framework based on self-evaluation submissions to Healthcare Improvement Scotland (HIS) from NHS boards. It has been developed in response to a requirement from the Scottish Government to better understand progress in embedding the National Framework across NHS Scotland and support greater consistency, transparency and shared learning at a system level.

This report summarises NHS boards' self-evaluation of how they believe the National Framework is being applied in practice and the extent to which local arrangements align with its expectations. Boards were asked by HIS to complete a structured self-evaluation against 12 statements aligned to the National Framework. The findings are drawn primarily from the boards' submissions, including qualitative narrative responses, self-reported compliance ratings and, in some cases, supporting documentation. While this approach enables insight into local perspectives, systems and priorities, it reflects how boards describe their own arrangements rather than providing an independently verified assessment of practice.

The findings are presented across four interconnected themes: governance arrangements, inclusion of patients and families, support to staff, and learning. There are important limitations that should be considered when interpreting these findings. The depth, quality and consistency of submissions varied, and a small number of boards provided supporting evidence to substantiate their self-evaluation. As a result, the analysis relies largely on self-reported information and may not fully capture the extent to which systems and processes are embedded or effective in practice. Variation in interpretation of the National Framework and differing governance structures also limit the ability to make direct comparisons across organisations. For these reasons, the report should be viewed as an indicative, point-in-time picture of implementation rather than a definitive assessment of compliance or impact.

We will be following up with NHS boards to gain a clearer understanding of the rationale and the evidence underpinning the assessment and their position within the red, amber and green (RAG) rating framework. HIS would like to thank NHS boards for the time and reflection involved in completing the self-evaluation. Their contributions signal where further engagement, targeted support and system-wide improvement activity is required to ensure that learning from adverse events is robust, meaningful and consistently translated into safer care for the people of Scotland.

Background

Healthcare services in Scotland operate in complex environments where risk cannot be eliminated. When adverse events occur, systems need to support learning and improvement to strengthen patient safety and quality of care. In February 2025, HIS published the National Framework in NHS Scotland setting out a best-practice, system-wide approach for NHS boards.

Following the Cabinet Secretary for Health and Social Care's letter of 29 September 2025 on the quality and timeliness of Significant Adverse Event Reviews (SAERs), HIS took forward work to strengthen national oversight and support more consistent application of the National Framework.

This report brings together learning from NHS board self-evaluations to highlight their perceived progress, variation, challenges and areas where further support may be needed. It also provides a baseline for ongoing monitoring and engagement to support a more coordinated and consistent approach to reviewing and learning from adverse events.

Methodology

HIS was asked by the Scottish Government to strengthen oversight and scrutiny of adverse event work and support adherence to the National Framework. In response, a self-evaluation tool was developed and sent to the 19 patient-facing territorial and special NHS boards (Appendix 1).

The evaluation tool was developed using HIS's Quality Management System (QMS) to support a consistent, transparent and proportionate approach. Twelve statements were derived from the National Framework and designed to support structured reflection on current practice, alignment and impact. Senior and executive managers reviewed the tool and feedback was also sought from internal colleagues and NHS board representatives.

A RAG rating system has been adopted to provide clearer assessment of compliance.

- Significant compliance (green): Systems and processes are fully embedded and learning from data and feedback informs continuous review and improvement.
- Moderate compliance (amber): Systems and processes are being developed and implemented. Some evidence is available to confirm learning informs continuous review and improvement.
- Limited compliance (red): Systems and processes are at an early stage of development with limited or no evidence of continuous review and improvement.

The tool assessed implementation across key areas of the National Framework, including:

- Governance and accountability – clarity of roles, responsibilities, and decision-making structures.
- Reporting and categorisation – consistency in adverse event reporting, classification and escalation.
- Review and analysis – adherence to commissioning criteria, review levels and documentation standards.
- Learning and improvement – mechanisms for sharing lessons learned and embedding improvements.
- Engagement and communication – involvement of patients/families and staff in the review process.
- Monitoring and assurance – alignment with risk management principles and compliance monitoring.

Reasoning

A self-evaluation approach was chosen to support openness, reflection and local ownership of improvement actions, while also providing HIS with a national baseline to inform future oversight and review.

Analysis of the qualitative submissions helps:

- Identifying where there is variation in the system in terms of embedding the National Framework.
- Identifying strengths, opportunities for improvement, gaps, challenges and variation in implementation.
- Informing targeted qualitative reviews going forward.
- Suggesting areas that require targeted improvements.

How the information was analysed

- Each submission was mapped to the relevant National Framework requirement.
- A SOAR approach (Strengths, Opportunities, Aspirations and Results) was used to structure the analysis. SOAR is a strengths-based framework that emphasises what is working well, identifies opportunities for development, captures future aspirations and defines intended results.
- Reported challenges were also considered through a systems and human factors lens, drawing on the SEIPS (systems engineering initiative for patient safety) framework.
- Self-reported compliance ratings were analysed quantitatively to identify broad patterns and variation across boards.

Important limitations

This report is based on self-evaluation, and the findings reflect what boards reported about their systems and progress. The self-evaluation reflects a point-in-time position and may be subject to variation in interpretation across boards, including differences in respondents and the absence of fully standardised definitions. This report should be read as an indication of current maturity rather than definitive assurance of implementation.

Overview of NHS Board Self-Reported RAG Status

The NHS board self-evaluation returns provide a baseline understanding of current approaches to implementing the National Framework. It also recognising that this has been in place for 8 months at the time the self-evaluation was completed. The returns highlight areas where boards have begun to embed the National Framework, alongside challenges in achieving consistent and high-quality approaches to reviewing and learning from adverse events.

Governance

The National Framework sets out expectations for governance arrangements to ensure adverse events are reviewed consistently, in a timely way, and lead to improvement. To assess this, the self-evaluation included requirements on categorisation and commissioning of reviews, completion

and escalation processes and governance structures with leadership oversight to monitor and track improvement actions. The graphs below present NHS boards' self-reported compliance against these requirements, highlighting overall patterns and variation in governance implementation.

Figure 1: NHS board compliance with requirement 1: All adverse events are consistently reviewed and categorised, with clear decision-making processes and governance in place.

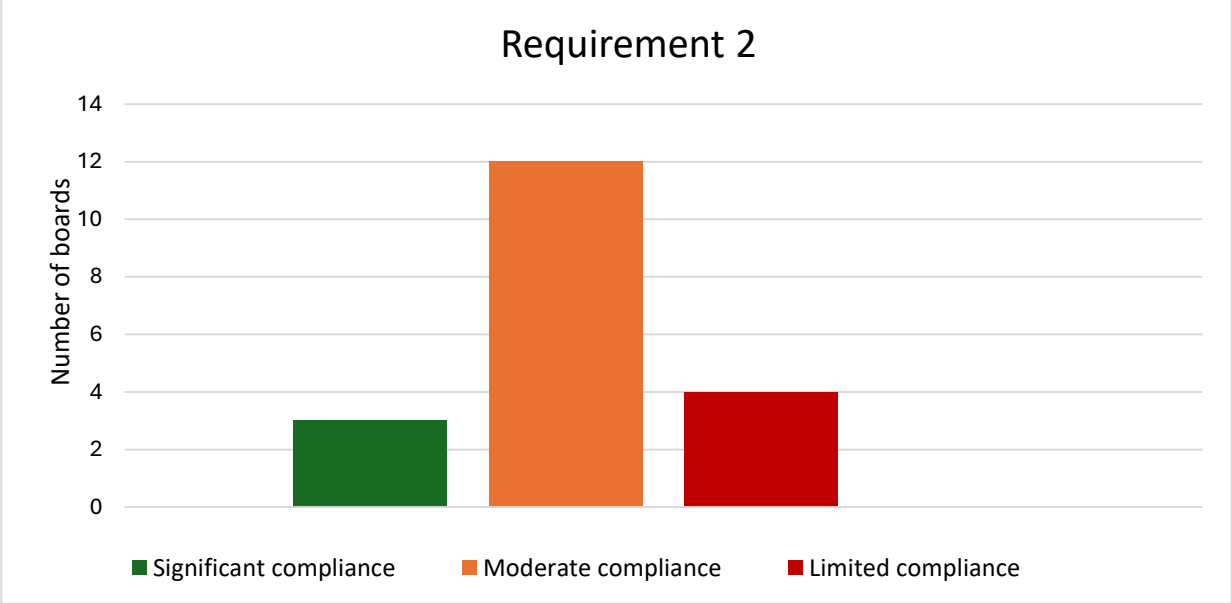

Figure 2: NHS board compliance with requirement 2: Our reviews are commissioned and completed in a timely fashion in adherence with the framework.

Figure 3: NHS board compliance with requirement 12: Our governance structures and leadership accountability are in place to support the implementation and monitoring of improvement actions.

Figures 1–3 indicate that NHS boards have largely established governance arrangements in line with the requirements but consistency in application remains variable.

For **requirement 1**: 11 boards reported significant compliance and 8 boards reported moderate compliance. This suggests governance structures and decision-making processes are in place, although consistent application is not yet fully embedded.

For **requirement 2**: 3 boards reported significant compliance, 12 boards reported moderate compliance and 4 boards reported limited compliance. This indicates that the expectation for timely reviews is not being consistently met.

For **requirement 12**: 9 boards reported significant compliance and 10 boards reported moderate compliance. This indicates that governance structures and leadership oversight are widely in place. However, variation in monitoring and tracking of improvement actions remains.

Overall, while boards demonstrate alignment with the National Framework in establishing governance systems, there remains a gap between structure and consistent timely delivery in practice.

Patients and families

The National Framework places an emphasis on person-centred involvement of patients/families throughout the review of significant adverse events. To assess this in practice, the self-evaluation included requirements on informing, supporting and meaningfully involving patients/families, including the use of named contacts and having systems to respond to their needs, concerns and complaints. The graphs below present NHS boards' self-reported compliance against these requirements, highlighting patterns and variation in patient/family involvement.

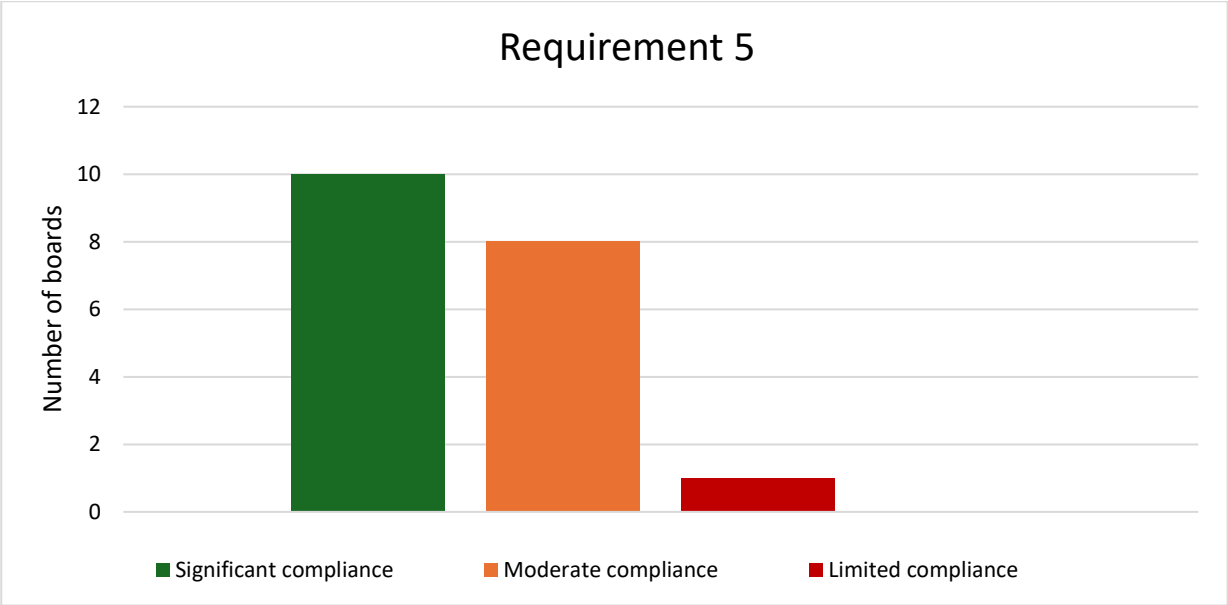

Figure 4: NHS board compliance with requirement 5: We ensure patients/families are informed, supported and meaningfully involved throughout the SAER process, including a named contact.

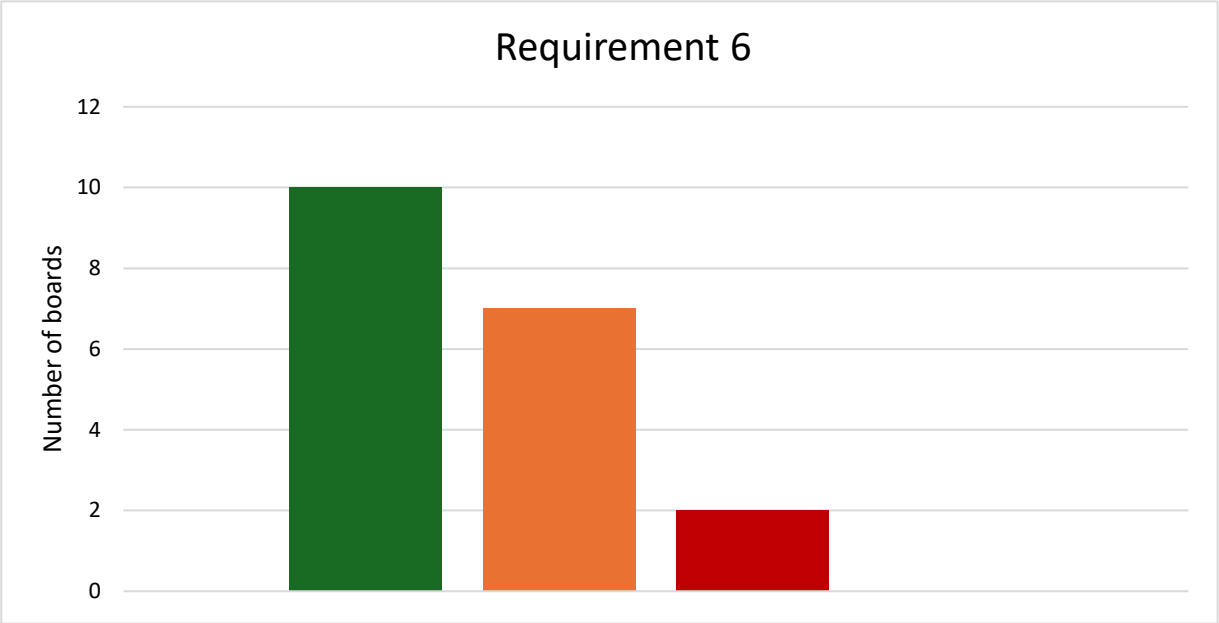

Figure 5: NHS board compliance with requirement 6: We have systems in place to respond to patient/family needs, concerns and complaints during and after the SAER.

Figures 4 and 5 indicate that NHS boards are progressing in implementing the requirements expectations on patient/family involvement, though consistency remains variable.

For **requirement 5**: 10 boards reported significant compliance, 8 boards reported moderate and 1 board reported limited. This suggests that processes for informing and involving patients/families are largely in place but not yet consistently applied.

For **requirement 6**: 10 boards reported significant compliance, 7 boards reported moderate and 2 boards reported limited compliance. This indicates variation in responding to patient/family needs, concerns and complaints.

Overall, while boards are broadly aligned with the requirements, variation in delivery means patient/family experience is not yet consistently equitable across NHS Scotland.

Support to staff

The National Framework emphasises the importance of a positive safety culture where staff are supported and able to contribute to learning and improvement. To assess this, the self-evaluation included requirements on promoting a safety culture, providing timely support such as debriefs and wellbeing resources, and ensuring staff are actively involved in the review process. The graphs below present NHS boards' self-reported compliance against these requirements, highlighting patterns and variation in support to staff.

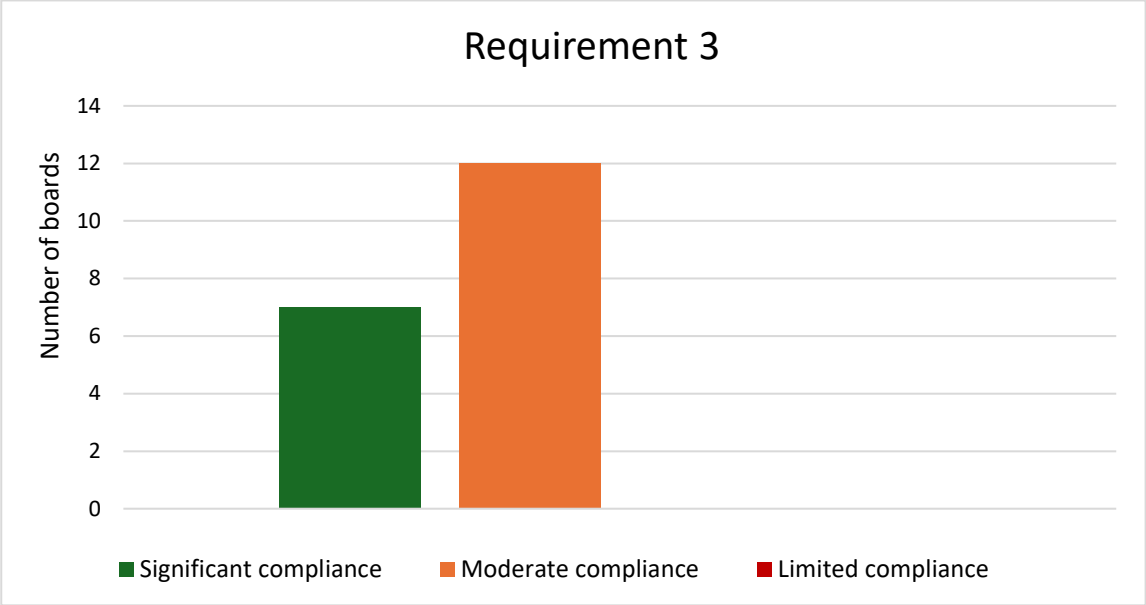

Figure 6: NHS board compliance with requirement 3: Our organisation prioritises a safety culture where all staff understand their roles and responsibilities in managing adverse events and are empowered to contribute to continuous improvement.

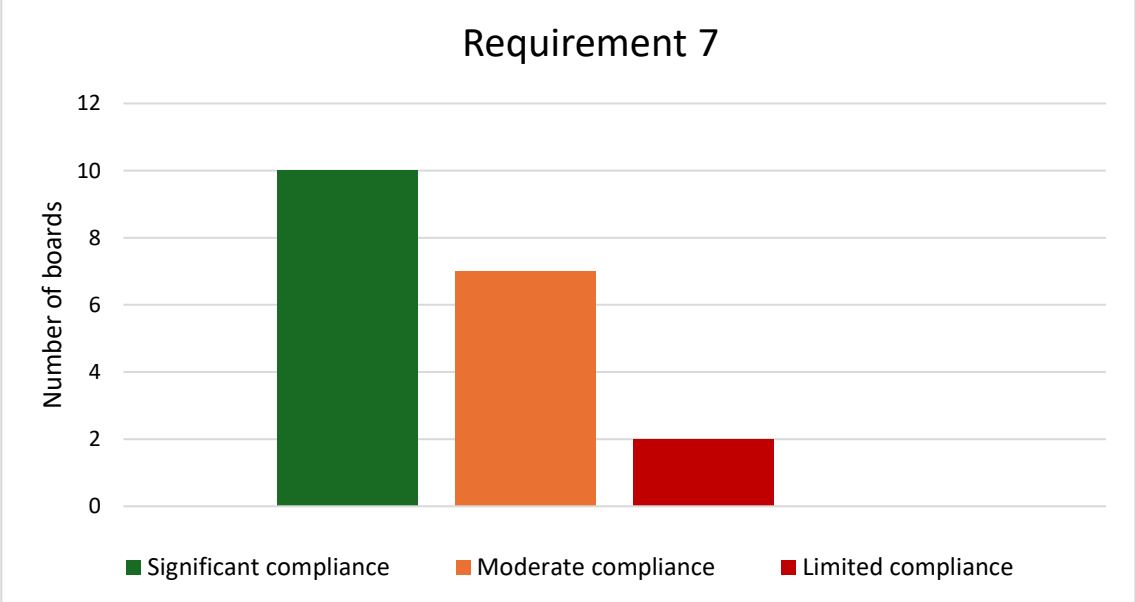

Figure 7: NHS board compliance with requirement 7: We support staff involved in an adverse event including timely debriefs to enable them to reflect. Where possible, staff are given the opportunity to work in a different team or environment following an adverse event.

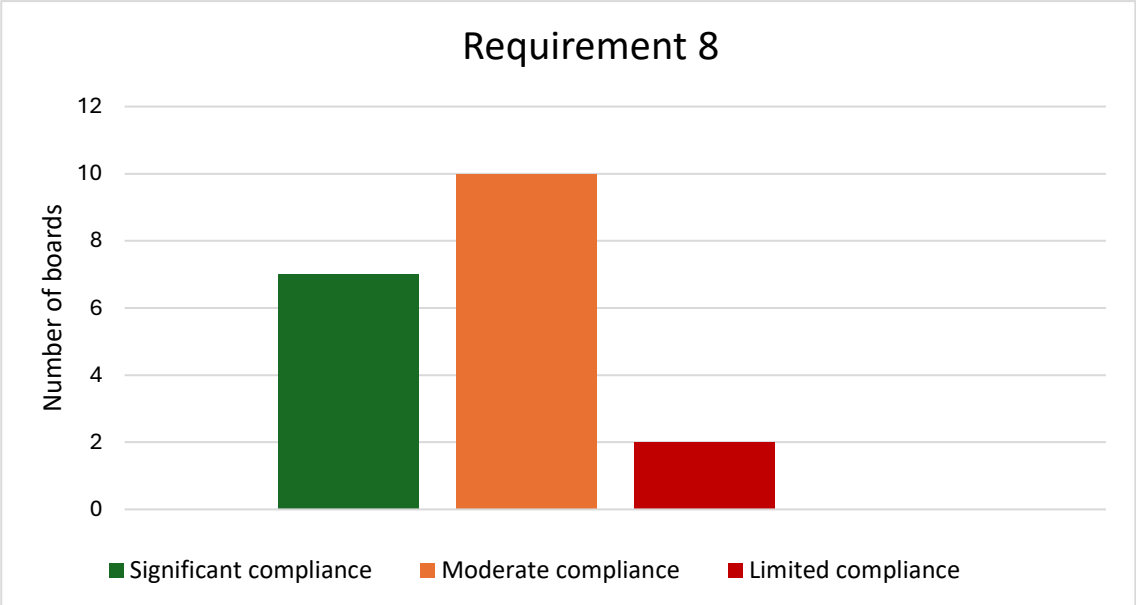

Figure 8: NHS board compliance with requirement 8: We have mechanisms in place to ensure staff are actively involved in the review process and informed throughout, including named contacts and factual accuracy checks.

Figures 6–8 show NHS boards' self-reported compliance with requirements relating to staff support, safety culture and involvement. The findings indicate that while systems are in place, implementation remains uneven.

For **requirement 3**: 7 boards reported significant compliance and 12 boards reported moderate compliance. This suggests that boards recognise, and are, developing a positive safety culture, though it is not yet fully embedded in practice.

For **requirement 7**: 10 boards reported significant compliance, 7 boards reported moderate compliance and 2 boards reported limited compliance. This indicates that support mechanisms such as debriefs are widely in place, but access and consistency vary.

For **requirement 8**: 7 boards reported significant compliance, 10 boards reported moderate compliance and 2 boards reported limited compliance. This suggests that while processes exist to involve staff, participation and communication are not yet fully established.

Overall, this suggests that while systems to support staff and promote safety culture are widely established, there is more variability in how staff are engaged as active participants in the review process itself.

Learning

The National Framework sets out expectations for a quality-driven approach to adverse event reviews, focused on identifying contributory factors, strengthening patient safety and embedding learning into practice. It emphasises the use of structured approaches including the HIS quality checklist (Appendix 2) and the importance of translating learning into sustained improvement.

To assess this in practice, the self-evaluation included requirements on the quality of reviews, identifying and embedding learning, sharing learning across organisations, evaluating its impact on safety and system-wide improvement, and using feedback from patients/families and staff to inform improvement. The graphs below present NHS boards' self-reported compliance against these requirements, highlighting patterns and variation in how learning is translated into improvement.

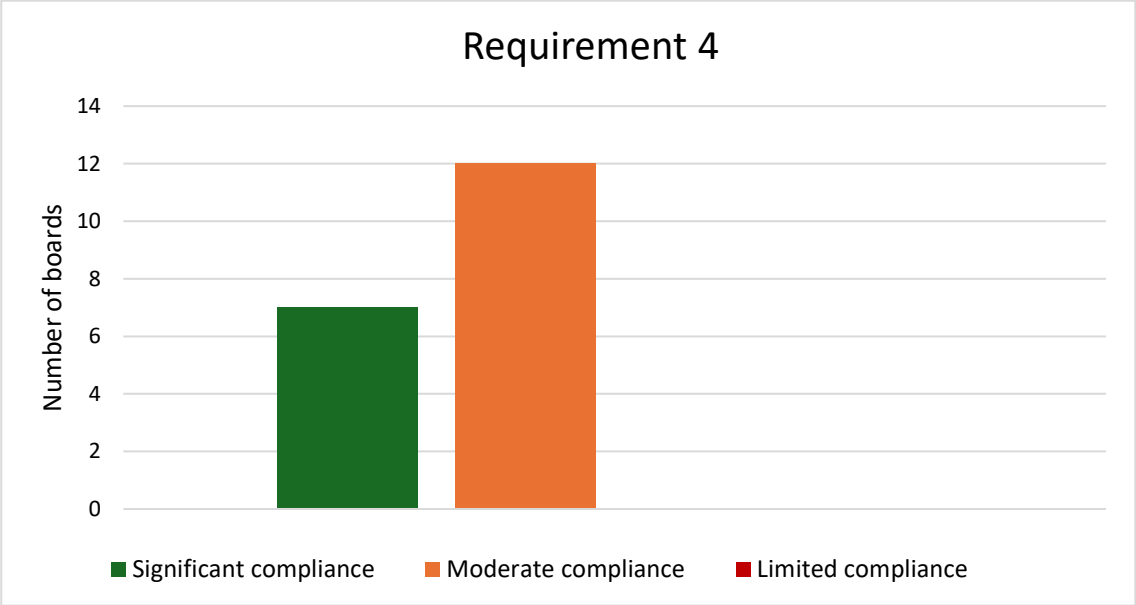

Figure 9: NHS board compliance with requirement 4: We take a quality-driven approach to ensure our reviews effectively identify contributory factors, strengthen patient safety, and support improvements in healthcare systems and processes. To maintain consistency and rigour, we use the Quality Checklist to guide and verify each step across the 6 stages of the adverse event review process.

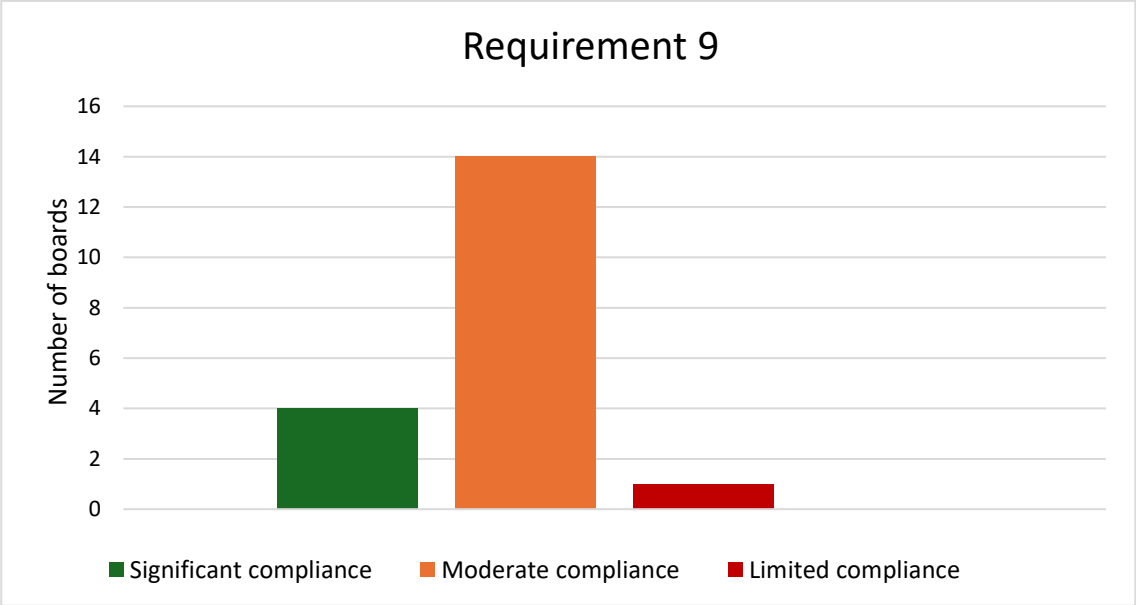

Figure 10: NHS board compliance with requirement 9: We ensure that learning from adverse events is identified, embedded, and translated into meaningful improvement.

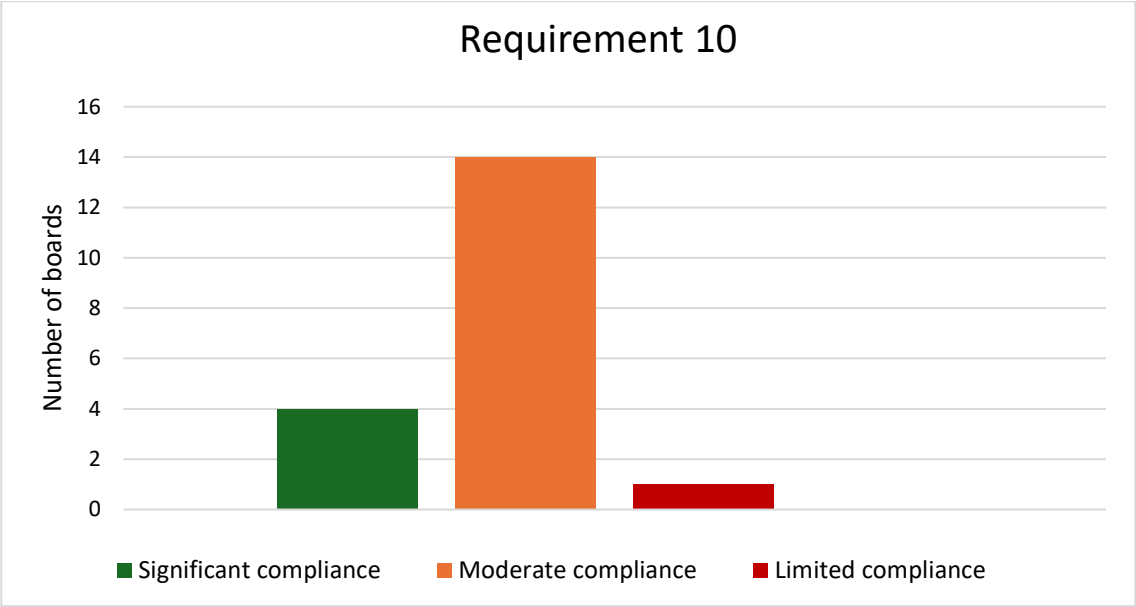

Figure 11: NHS board compliance with requirement 10: Learning is shared across the organisation and its impact on safety and system wide improvement is evaluated.

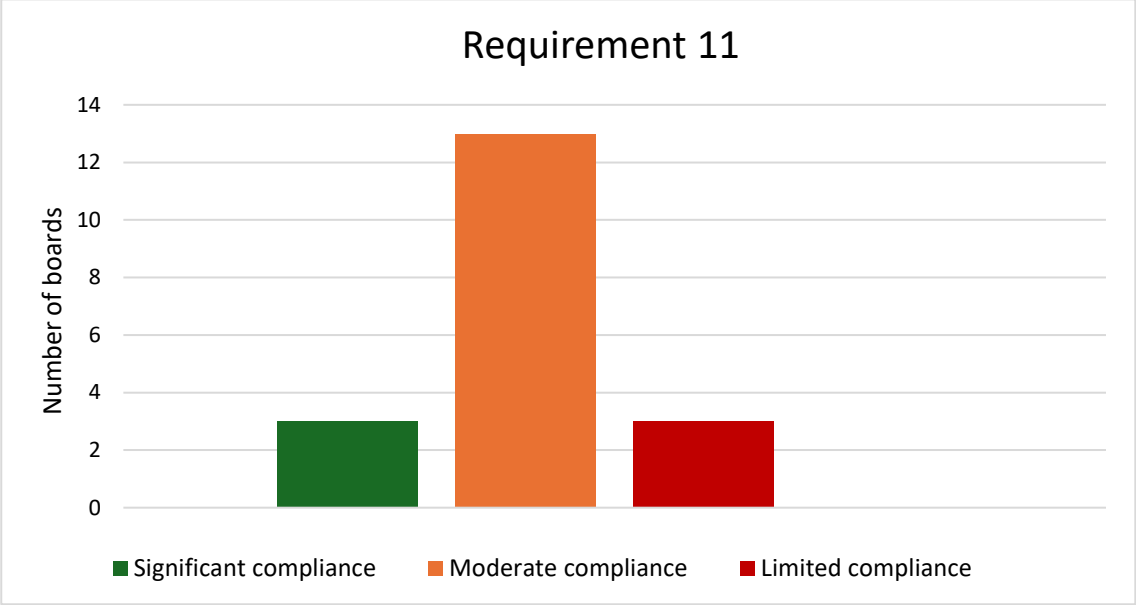

Figure 12: NHS board compliance with requirement 11: Patients/families and staff feedback is used to improve systems, share learning and strengthen organisational responsiveness to adverse events.

Figures 9–12 show NHS boards' self-reported compliance with requirements relating to the quality of reviews, embedding learning, sharing learning and using feedback.

For **requirement 4**: 7 boards reported significant compliance and 12 boards reported moderate compliance. This suggests that quality driven review processes are in place but not yet fully embedded across all boards.

For **requirement 9**: 7 boards reported significant compliance, 14 boards reported moderate compliance and 1 board reported limited compliance. This indicates that translating learning into measurable improvement remains a key challenge.

For **requirement 10**: 4 boards reported significant compliance, 14 boards reported moderate compliance and 1 board reported limited compliance. This suggests that while learning is shared, evaluation of its impact is underdeveloped.

For **requirement 11**: 3 boards reported significant compliance, 13 reported moderate compliance and 3 reported limited compliance. This indicates that while feedback mechanisms exist, they are not yet consistently used to inform learning and improvement.

Overall, boards are broadly aligned with the requirements in having processes in place to identify, share and act on learning. However, variation in how these processes is applied and in the quality of actions developed remains a concern. In addition, inconsistent monitoring of impact means that learning and feedback are not yet translating into measurable and sustained improvement across NHS Scotland.

Key findings

Key findings are based on analysis of boards' self-reported assessments of their current compliance with the National Framework. This includes the evidence provided to support this position and their descriptions of the learning, improvement needs and challenges affecting delivery.

Governance arrangements (incorporating requirement 1, 2 and 12)

Governance overview statement

Boards described governance frameworks that align with the expectations of the National Framework, including defined roles, multi-disciplinary review structures and formal processes for commissioning and oversight of adverse event reviews. Boards reported understanding national requirements for review categorisation, commissioning and timescales. However, boards also described variation in how these arrangements are applied in practice. Submissions highlighted differences in escalation thresholds, senior leadership visibility and the reliability of digital monitoring systems. Operational delivery of timely reviews is reported to be inconsistent, influenced by local process complexity, capacity constraints, documentation gaps and external dependencies. In some areas, reliance on manual tracking is reported to reduce the predictability of oversight and limit confidence in the monitoring of improvement actions.

Requirement 1

> *All adverse events are consistently reviewed and categorised, with clear decision-making processes and governance in place.*
>
> *National Framework: Reviewing an adverse event: page 12, 16 and 62*

All boards reported that they have decision-making roles defined; have developed system-based workflows supported by approaches including SBARs, (Situation, Background, Assessment, Recommendation) trigger lists, escalation tools and automated digital alerts. These tools can support visibility and escalation. Governance structures are described at both operational and executive levels providing lines of accountability.

Seventeen of the 19 boards reported that their policies are aligned, or being aligned, to the National Framework. Two boards reported that they are not yet aligned: 1 board plans to begin this work later in 2026, while another board described implementation in 1 clinical area but gave no timescale for board-wide rollout.

However, gaps remain in the categorisation and commissioning of adverse event reviews. Differences in how boards interpret Category 1 thresholds and Level 1 commissioning criteria, and how they distinguish between adverse outcomes and adverse events, reduces consistency across the system. Delays at key points in the process, such as initial assessment and commissioning decisions, also limit boards' ability to demonstrate consistent decision-making. These inconsistencies mean that similar risks may be handled differently, which can delay escalation or result in incidents not receiving the level of scrutiny required.

Documentation was described as variable in completeness and quality across several areas, including decision logs, commissioning terms of reference and closure evidence. Strengthening documentation will support boards to more clearly demonstrate accountability, audit readiness and proportionality of decision-making and enhance overall governance assurance.

Capability needs remain for commissioners and review leads, reinforcing the need for routine calibration and targeted training in human factors and systems thinking. The human factors and systems thinking approach, recognises that safety and quality are influenced by the interaction between people, processes, environments and organisational systems, rather than individual actions alone. Using this approach will enable and support boards to get a deeper understanding of underlying system causes and support learning-focused improvement.

All boards described systems that are becoming more organised and increasingly supported by automation. These systems enable categorisation, tracking and escalation, automated prompts for higher-severity cases, routine governance reporting and the use of dashboards and trackers. These arrangements provide visibility and contribute to governance processes, including scrutiny, calibration and escalation.

Requirement 2

> *Our reviews are commissioned and completed in a timely fashion in adherence with the framework.*
>
> *National Framework: Reviewing an adverse event: page 13, 18, 19 and 21*

All boards described structures to support timely commissioning and completion of reviews, including governance meetings, escalation pathways, trackers, dashboards and commissioning templates. These are also used to monitor progress. Boards described administrative processes with checklists, pre-meetings, terms of reference discussions and regular contact between governance teams and lead reviewers. All boards outline how adverse events are categorised and how progress is overseen through clinical governance forums.

Delays in commissioning and progressing reviews were common, with only 3 boards reporting significant compliance, 12 boards reporting moderate compliance and 4 boards reporting limited

compliance with timescales. This indicates that the requirement is not being met reliably across boards.

The main reasons for delays included limited reviewer capacity, inconsistent application of policies, variation in system use, external information delays, complex multi-board events and manual administrative processes. For example, 1 board cited delays linked to external dependencies such as Procurator Fiscal processes, toxicology and postmortem results, while another board highlighted reliance on third-party suppliers and information from other NHS boards.

Additional factors included delays in assigning lead reviewers, variation in local workflows, lack of protected time for reviewers and challenges associated with complex cases or external dependencies. Boards also reported ongoing pressure in balancing review work with operational demands. In addressing these challenges, 4 boards identified the need for clearer guidance, 2 boards highlighted the importance of more reliable data and 3 boards called for stronger cross-board collaboration.

These delays reduce the timeliness and relevance of reviews, limiting opportunities for learning, improvement and weakening the overall effectiveness of the adverse event review process.

Boards identified opportunities to strengthen practice. Eleven boards noted the importance of increasing reviewer capacity and confidence through training and peer support. In addition, 6 boards identified improving data quality, 4 boards noted the need to strengthen escalation triggers and 2 boards noted opportunities to reduce duplication across processes. Progress in these areas may support more timely commissioning, monitoring and escalation of reviews in line with the requirement.

Requirement 12

> *Our governance structures and leadership accountability are in place to support the implementation and monitoring of improvement actions.*
>
> *National Framework: Identifying learning and improvement: page 57*

NHS Scotland's boards described governance structures in place to support executive oversight from the point of commissioning reviews through to action completion. Boards described sign-off processes involving two or three levels, including governance groups such as adverse event review groups, local and corporate oversight committees, clinical governance committees, SAER panels and system-wide leadership groups.

Boards who described less-effective arrangements described inconsistent or reactive involvement. Challenges include limited senior visibility of progress, differing standards across services and difficulty sustaining reliable tracking due to workload, manual processes or system-level pressures. This variation in oversight means that organisational risks may be prioritised differently across services, which can delay decision-making and weaken leadership assurance. These gaps reduce the reliability of improvement processes and create variation in how effectively learning is embedded across the organisation.

All boards reported that they have escalation processes, but thresholds and triggers are not consistently applied. This leads to delays in addressing overdue or stalled actions. When escalation is unpredictable, it increases the time that risks remain unmitigated and reduces accountability for progressing improvement actions.

Boards described using digital systems to support the implementation and monitoring of improvement actions. This includes assigning actions, tracking deadlines and reviewing progress, with support from risk coordinators, patient safety teams and quality assurance groups. Systems such as Datix, Healthcare Guardian, Pentana and QlikView are in use across boards.

Boards identified opportunities to further develop the use of these systems, including addressing capacity constraints, reducing reliance on manual follow-up and improving data quality. Improving the reliability of data and increasing consistency in the use of digital tools may support more accurate tracking of progress and reporting to governance committees. This may assist boards in monitoring and describing the impact of improvement actions.

All boards acknowledged the importance of SMART (Specific, Measurable, Attainable, Relevant, Timebound) principles in supporting effective action plans. There was a consistent message that the quality of action plans varies due to inconsistent application of SMART principles, limiting measurable outcomes and reducing the credibility of improvement planning. Five boards stated they are offering, or intend to offer, training to staff and 4 boards recognised the need for further training in SMART. Training and clearer defined actions may support demonstration of progress and alignment of improvements with identified causes of incidents.

Inclusion of patients/families (including requirement 5 and 6)

Overview of Inclusion of patients/families

Boards reported progress towards more structured and person-centred involvement of patients/families during a SAER. Submissions described communication practices such as early contact and the introduction of named contact roles to support continuity and navigation of the review process. However, boards also reported that involvement is not yet applied consistently. Variability in local processes, staff capacity and documentation affects the reliability of engagement and limits boards' ability to evidence meaningful involvement. Emotional support pathways, access to bereavement and third-sector services, and the availability of accessible information are reported to vary, affecting the consistency and equity of patient/family experience.

Requirement 5

> *We ensure patients/families are informed, supported and meaningfully involved throughout the SAER process, including a named contact.*
>
> *National Framework: Patient/family involvement in a Significant Adverse Event: page 32*

Eleven boards described communication taking place with patients/families following a SAER being commissioned. Early, clear information reduces uncertainty and distress for patients/families and establishes trust in the review process.

Twelve boards reported the use of a named contact to support patients/families throughout the review process, while the remaining boards described involving, or engaging, patients/families to varying degrees during the review. Allocating a named contact improves consistency, reassurance and accountability, which are essential for meaningful involvement rather than fragmented communication.

Thirteen boards described approaches to help patients/families understand the review process, including leaflets, letters, toolkits, phone calls and face-to-face meetings. Where person-centred approaches are used to help patients/families understand the review process, this supports informed decision-making and enables meaningful involvement in ways that reflect individual needs. This highlights the importance of embedding these approaches consistently across all boards to ensure equitable experiences for patients/families.

The analysis showed that person-centred involvement remains variable across boards. Although named contacts are commonly described, 5 boards reported difficulties allocating due to capacity challenges, with 3 boards specifically citing time constraints that limit regular communication and consistent delivery of the named contact role. Four boards identified resource pressures and 4 boards highlighted limitations in access to training, while 4 boards reported staff apprehension when managing complex or emotionally sensitive conversations. Variation was also noted in the use of bereavement, spiritual care and voluntary sector supports, with 1 board identifying challenges in assessing the appropriate level of support for patients/families.

These challenges highlight opportunities to strengthen how patients/families are supported during SAERs to ensure they receive timely, consistent and equitable information. Variation in staff capacity, access to training and confidence can affect the timeliness and quality of engagement. This highlights the need for a more systematic approach to supporting person-centred involvement, including strengthening workforce capacity, improving access to training and providing clearer guidance and tools to support staff in delivering the named contact role. Greater consistency in access to support services and clearer pathways for assessing and responding to patient/family needs will be critical to ensuring equitable, high-quality engagement across boards.

Requirement 6

> *We have systems in place to respond to patient/family needs, concerns, and complaints during and after the SAER.*
>
> *National Framework: Patient/family involvement in a Significant Adverse Events Review: page 40*

The analysis shows that, while all boards have some systems in place, there is significant inconsistency in patient/family involvement, emotional support, clarity of communication and end-of-process engagement.

Fourteen boards reported opportunities for patient/family involvement, but submissions showed variation in when this happens, how clearly the purpose is explained and how far people can influence the review. This variation means that the quality and impact of patient/family involvement is inconsistent, potentially affecting understanding, trust and the perceived fairness of the SAER process across boards.

Only 3 boards specifically referenced signposting to emotional support in their returns. Two boards mentioned patient information leaflets, 2 boards mentioned patient experience teams and 5 boards reported providing links to relevant support services. While 4 boards described apologising and maintaining communication with patients/families, emotional support was not consistently articulated as a distinct, or routine, element of the SAER process. Where this is not clearly described within local systems, there is a risk that patients/families receive differing levels of emotional support depending on the board. This increases the potential for inequitable experiences and unmet emotional needs at a distressing time.

Nine boards highlighted signposting arrangements, including access to advice, support services or further information. Six boards specifically referenced formal complaints handling routes through the NHS complaints process and/or escalation to the Scottish Public Services Ombudsman (SPSO). While this demonstrates that escalation pathways are in place, the relatively limited number explicitly referencing formal complaints handling may mean that some patients/families are not consistently supported to understand their options if concerns remain unresolved.

Eight boards reported that meetings with patients/families take place as part of the SAER process. Only 3 boards reporting that meetings are routinely offered at the conclusion of the review. This indicates variation in end-of-process engagement and suggests that patients and families are not consistently offered an opportunity to discuss findings and seek clarification at the conclusion of the review.

The consistent offer of an end-of-review meeting would support shared understanding, provide reassurance and enhance learning. It would also help reduce the likelihood of unresolved questions, or dissatisfaction, and strengthen confidence in the SAER process. Embedding this approach more consistently across boards may also help reduce avoidable escalation through complaints or external review routes.

Support to staff (including requirement 3, 7 and 8)

Overview of support of staff

All boards reported a commitment to fostering a positive safety culture, supported by policies, governance arrangements and training. Self-evaluations described the presence of mechanisms to involve staff in adverse event reviews, including early communication, named contacts and factual accuracy checks. Boards also reported that support for staff affected by adverse events is valued, particularly where debriefs, wellbeing services and trauma-informed approaches are available. However, staff experience is described as variable. Inconsistent application of involvement mechanisms, capacity constraints and limited opportunities for alternative duties affect the reliability of support. Boards reported limited data to understand the effectiveness of staff support and involvement arrangements.

Requirement 3

> *Our organisation prioritises a safety culture where all staff understand their roles and responsibilities in managing adverse events and are empowered to contribute to continuous improvement.*
>
> *National Framework: Reviewing an adverse event: page 12, 29 and 30*

All boards recognised the importance of safety culture as an enabler of safety and continuous improvement, and many referred to this in their self-evaluation returns. Ten boards referred to organisational culture. Of these, 6 boards described a culture that encourages, promotes or prioritises safety, while 1 board referred to maintaining a safety culture and 3 boards referenced a just culture. Two boards described culture in the context of learning, and 3 boards specifically highlighted a reporting culture. Across the returns, only 1 board described promoting psychological safety.

This variation suggests that, although many boards value a positive safety culture, it is not yet described, or prioritised, consistently enough to support a reliable staff experience across NHS Scotland. Prioritising a safety culture would support a more consistent staff experience, by clearly defining expectations, reinforcing roles and responsibilities, and promoting behaviours such as speaking up, openness and shared learning.

NHS Scotland boards reported that staff understanding of roles and responsibilities, in managing adverse events, is supported through a range of mechanisms. Eleven boards described how these are contained within local adverse event management policies and procedures. Four boards reported that they support staff through corporate induction programmes, while 8 boards highlighted the provision of training in adverse event management, including access to online training resources. However, the variation in approaches suggests that staff understanding may not be implemented consistently across all boards which could impact the reliability of reporting, review and learning processes. Strengthening alignment between policy, induction and training, alongside ensuring all staff have regular access to role-specific guidance and development, will reduce variability and improve the reliability of reporting.

Staff are supported to contribute to continuous improvement through training and development. Twelve boards referenced this in their returns with corporate induction, mandatory modules, role specific training, quality improvement training and SAER investigation programmes as some examples recorded. Training ensures staff understand not only how to report adverse events, but how reviews are undertaken and how learning should be translated into improvement. Access to Quality Improvement (QI) training, and collaboratives, can help support staff to apply improvement methodology to issues identified through adverse event learning.

Four boards described promoting learning when things go wrong, rather than a culture of fear or blame. Two boards specifically mentioned speak up and whistleblowing arrangements as additional mechanisms. These approaches, alongside structured governance, learning forums and cultural enablers such as just culture principles, create supportive conditions for staff. Promoting this culture empowers staff to report adverse events, engage in reviews and suggest improvements, further enabling them to influence positive change.

However, there are several barriers to consistently meeting this requirement. Seven boards reported competing priorities, 6 boards reported capacity issues, 5 boards highlighted time, 4 boards reported training while 3 boards reported complexity. Other challenges identified included digital barriers, limited operational staff awareness and involvement in process, confusion among frontline staff about what constitutes an adverse event, difficulty maintaining a reporting culture, knowledge gaps and financial pressures.

These factors limit the consistent prioritisation of a safety culture in practice, reducing staff opportunity and confidence to fully understand their roles, engage with adverse event processes and contribute to continuous improvement, particularly in frontline settings. Addressing these issues would support boards to more consistently embed a safety culture, strengthen staff understanding, engagement and empowerment in adverse event management, and enable more effective learning and improvement across NHS Scotland.

Requirement 7

> *We support staff involved in an adverse event including timely debriefs to enable them to reflect. Where possible, staff are given the opportunity to work in a different team or environment following an adverse event.*
>
> *National Framework: Staff involved in an Adverse Event: page 47 to 54*

All boards recognised the importance of supporting staff involved in adverse events. Twelve boards reported using debriefs, while 11 boards noted that staff support is reflected in policies and procedures. Six boards highlighted guidance for managers, 9 boards described providing direct support, and 10 boards reported signposting to support, with 3 boards specifically referencing staff leaflets. This indicates that staff support is widely understood and embedded at policy level, with common approaches including debriefs and signposting.

Several boards described a variety of sources of support for staff involved in adverse events. This included 6 boards reporting occupational health, 5 boards describing peer support and 1 board spiritual care. Six boards have produced guidance for managers, such as flowcharts, checklists and staff leaflets to explain what support should be offered. Three boards are introducing new guidance from psychology teams to help managers recognise distress and respond appropriately. While this demonstrates boards are taking steps to formalise and strengthen support for staff following adverse events, it is not yet consistent across NHS Scotland. Strengthening alignment between available services, manager guidance and psychological support, alongside increasing visibility and uptake, will be important to ensure support is reliably embedded rather than dependent on local variation.

Boards identified several challenges. The 3 main issues were limited time for supporting staff, particularly for debrief sessions, insufficient training for staff in support roles, and inconsistencies in processes arising from variations in local management structures across boards. Formalising and strengthening staff support arrangements would provide those staff involved with timely and appropriate access to the right support following an adverse event, regardless of role, service or board.

The requirement states that, where possible, boards should give staff the opportunity to work in a different team or environment following an adverse event. Nine boards referred to this aspect of the requirement. Three boards advised that they do consider moving staff, although 1 board noted that the responsibility for this sits with a different department. Five boards reported limited opportunities for staff to move, while 4 boards advised that they do not consider moving staff. Opportunities for staff to work in a different team or environment may help enhance wellbeing and recovery and boards should expand this where possible.

Overall, boards recognise the need to strengthen staff support, but further work is needed on training, debrief capacity, documentation and clearer pathways for alternative duties. Better data and quality assurance would also help boards understand what support is working. With proactive efforts, boards can continue moving toward a culture where staff feel supported when involved in adverse event reviews.

Requirement 8

> *We have mechanisms in place to ensure staff are actively involved in the review process and informed throughout, including named contacts and factual accuracy checks.*
>
> *Staff involved in an Adverse Event: page 52 and 53*

All NHS Scotland boards described mechanisms to ensure staff are actively involved and informed during adverse event reviews; however, the type and extent of these mechanisms vary. Five boards, from all responses, described allocating a nominated contact for staff with 2 boards reporting they have not yet introduced a named contact role. Having a named contact role can assist in providing continuity, clarity and confidence for staff throughout the review process.

The self-evaluation responses show that opportunities to be involved in the review are not always applied evenly across boards. Five boards reported providing staff with information leaflets and 3 boards offered dedicated staff support. Access to information and support for staff plays an important role in supporting understanding of the review process and learning.

Enabling staff to participate in the review process and contribute to the report supports meaningful engagement and enhances understanding of review findings and learning. However, only 6 boards reported that they provide staff with an opportunity to review the report and 10 boards reported providing a copy of the final report with 4 boards involving staff in factual accuracy checks.

Several challenges were reported that affect how consistently this requirement is met in practice. Factual accuracy checks are not applied consistently and opportunities for staff to provide feedback, or meaningfully contribute, to reports can be limited. Time pressures, capacity constraints and staff availability can make it difficult to maintain staff involvement throughout the full review. In some cases, unclear communication can lead to uncertainty about how and when they can contribute. Additionally, not all staff across all boards are routinely invited to participate in reviews, which further contributes to variation in meeting this requirement.

The analysis indicates a need for greater clarity and consistency in how staff involvement is facilitated in practice, particularly in relation to opportunities to contribute and engage at different stages of the review. The variation observed suggests that existing approaches are not yet consistently embedded, and that expectations around staff involvement may not always be clearly defined or applied.

Learning (including requirement 4, 9, 10 and 11)

Overview of learning

Boards are developing quality-driven approaches to adverse event reviews and learning. Learning is being identified through reviews and shared via summaries, governance groups and emerging thematic approaches. However, some boards report variation in the depth and consistency of systems-based analysis, reflecting differences in reviewer capability and confidence. Translation of learning into embedded, measurable improvement is described as inconsistent. Boards note variation in action quality, follow-through and impact monitoring, with digital systems to support action tracking and oversight at different stages of maturity. Mechanisms to evaluate whether learning leads to sustained change, reduced risk or prevention of recurrence are reported to be underdeveloped, and feedback from patients/families and staff is not yet consistently analysed or linked to assurance.

Requirement 4

> *We take a quality-driven approach to ensure our reviews effectively identify contributory factors, strengthen patient safety and support improvements in healthcare systems and processes. To maintain consistency and rigour, we use the Quality Checklist to guide and verify each step across the six stages of the adverse event review process*.
>
> *National Framework: Quality of review: page 29*

Across NHS Scotland, boards reported that systems and processes for a quality-driven approach to adverse event review are developing. A quality-driven approach involves applying the National Framework to adverse event reviews. This recommends the use of the HIS quality checklist, using human factors and systems thinking to identify contributory factors, ensure robust analysis and translate learning into sustained improvements in patient safety.

The requirement asks whether boards take a quality-driven approach that identifies contributory factors, strengthens patient safety and supports system improvements. Boards described a variety of structured methods including governance oversight to guide high quality reviews. Seven boards reported using human factors and systems engineering approaches during adverse event reviews. One board reported plans to introduce a human factors approach while, a further 6 boards are working towards strengthening identification of contributory factors through the provision of training over the coming year. In addition, 9 boards described offering a range of training opportunities, including human factors and systems thinking, practical application of review tools, leading reviews using the care system analysis tool, team-based quality review, and the Public Services Delivery Scotland learning response review tool.

This suggests that, while there is growing use of structured approaches and investment in training, these are not yet applied uniformly across all boards. This could limit the identification of contributory factors and reduce the impact of learning on system improvement.

From analysis, 11 boards reported and described aligning their processes to the six-stage model outlined in the HIS quality checklist and a further 3 boards are working to embed it within their local systems. The quality checklist is intended to shape and support consistent practice in the review process.

Embedding a quality-driven approach across Scotland will support the identification of contributory factors, strengthen patient safety, and enhance learning and improvement.

Requirement 9

> *We ensure that learning from adverse events is identified, embedded, and translated into meaningful improvement.*
>
> *National Framework: Identifying learning and improvement: Page 55 and 56*

Eleven boards reported they use SMART action planning and described a range of structures, processes and tools used to support this. These include policies, procedures, SAER pathways and governance groups that review findings and develop actions. This reflects work underway to identify, embed and act on learning from adverse events.

Variation in how SMART principles are applied leads to differences in the quality of improvement actions. This makes oversight and assurance more difficult and increases the risk that learning does not translate into consistent or lasting improvement.

There was acknowledgement of challenges in converting findings into measurable improvements, embedding actions across services and evidencing impact. Seven boards highlighted that confidence and competence in applying SMART principles was one challenge, while 4 boards specifically cited reviewer and commissioner confidence alongside wider system pressures. One board also raised concerns about the psychological safety of expressing strong opinions on recommendations. This limits boards' ability to consistently translate findings into clear, measurable actions, undermining confidence, weakening assurance, and making it difficult to evidence and sustain improvement across services. Further training in developing SMART actions would help boards to build staff confidence.

Eleven boards highlighted that monitoring improvement actions needs strengthened. To facilitate learning being translated into improvement actions, boards described mechanisms to record, assign owners and provide support. Six boards described using their digital systems to support monitoring and oversight of actions. Other mechanisms described include learning summaries, peer review, staff engagement and links to improvement methodologies. Strengthening oversight, use of digital systems and alignment with improvement methodologies will be important to ensure that actions are not only recorded but progressed, evaluated and sustained. This will enable learning to be translated into demonstrable improvements in practice and patient safety. Oversight of improvement actions helps to ensure that learning from adverse events is translated into timely, effective, and sustained improvement.

Significant system-wide opportunities remain to strengthen how learning is translated into effective and sustained improvement. Enhancing the quality of recommendations, strengthening the application of SMART principles and improving the monitoring of actions will increase confidence that improvements are implemented and maintained. Addressing variation in digital capability will support better visibility and oversight across boards, while developing staff skills and confidence and creating protected time for improvement activity can promote greater engagement in learning processes.

While systems to support learning are in place, further work is needed to ensure consistent application in identifying, embedding and translating learning into improvements in practice and patient safety. Strengthening approach, capability and oversight will support boards to realise the full impact of adverse event learning and deliver meaningful, sustained improvement.

Requirement 10

> *Learning is shared across the organisation and its impact on safety and system wide improvement is evaluated.*
>
> *National Framework: Identifying learning and improvement: Page 57 and 58*

All boards across NHS Scotland reported sharing learning across organisations and described a range of mechanisms to support this. These included learning bulletins, staff briefings, newsletters, presentations, practice education teams and learning events. Digital platforms such as Teams and email were also used to circulate learning summaries and facilitate discussion across governance groups, teams and services. However, the extent, and regularity, of these activities vary. This indicates areas where there is variation in the consistency of learning sharing and the evaluation of its impact, including how learning is used to inform system-wide improvement and recurrence in practice.

Based on self-evaluations, 12 boards reported routine use of a learning summary following AERs, with a further 6 boards reviewing or planning implementation and 1 board using an alternative approach through learning notices. While this indicates widespread adoption and standardised use, it is not yet fully embedded. Adoption of the standardised learning summary template across all boards would support greater consistency in capturing and sharing learning, enabling thematic analysis and supporting evaluation of its impact on safety and system-wide improvement, in line with the National Framework.

Fifteen boards reported having governance oversight arrangements in place for learning summaries arising from adverse event reviews. Governance oversight of learning summaries supports the National Framework's commitment to consistent and coordinated learning. Without governance oversight of learning from adverse events, boards cannot be confident that identified learning is acted on, embedded in practice, or contributes to reducing the risk of recurrence, resulting in missed opportunities for system-wide improvement and increased potential for repeated harm.

However, board returns indicated a continued focus on actions, rather than impact on safety and system-wide improvement, with 13 boards identifying this as an area for improvement. Examples of planned improvements include strengthening feedback loops, tracking learning, enhancing digital systems, developing analytics, thematic reporting and quality improvement projects. These approaches would support a shift from action-focused activity to a clearer focus on system-wide improvement, enabling boards to evidence that learning from adverse events leads to sustained improvements in patient safety.

Overall, boards demonstrated a commitment to sharing learning from adverse events. However, variation remains in the consistent use of learning summaries, governance oversight and evaluation of impact. This means boards are not consistently able to demonstrate that learning is reliably embedded, supports reduction in the risk of recurrence or leads to sustained improvement in patient safety.

Requirement 11

> *Patients/families and staff feedback is used to improve systems, share learning, and strengthen organisational responsiveness to adverse events.*
>
> *National Framework: Patient/family involvement in a Significant Adverse Event Review: Page 37 and Identifying learning and improvement: page 55*

Boards described a range of mechanisms for gathering feedback from patients/families and staff. This included informal conversations, meetings, surveys, QR codes linked to surveys and routine engagement during the review process. Thirteen boards reported seeking feedback as part of their processes, while 7 boards noted that further work is required to embed this in line with National Framework expectations. This indicates that feedback is not consistently or systematically used to inform improvement, share learning or guide organisational responses to adverse events.

Boards reported challenges such as low response rates from patients/families, which may mean feedback is incomplete or weighted towards negative experiences. This affects the extent to which feedback can be used to inform improvement actions. Enhancing feedback mechanisms to improve accessibility and, inclusivity and, triangulate patient/family feedback with additional sources to support a more balanced understanding of experience would help strengthen engagement.

Boards provided limited information on how staff feedback is gathered, with some reporting limited experience in seeking staff views or recognising that staff may lack confidence in contributing. Where feedback is not gathered routinely, opportunities to learn from experience and inform system improvement may be reduced.

Boards recognised that feedback may contribute to decision-making, review processes and reporting, but also acknowledged that it is not always easy to demonstrate how feedback has been used. This can reduce trust and limit engagement. Additionally, there was recognition of the importance of maintaining contact with those who provide feedback, enabling boards to continue to draw on lived experience to identify areas for improvement and strengthen understanding of patient/family and staff perspectives.

Boards identified constraints such as resource, time and competing demands as barriers to consistently gathering feedback and using it to share learning and improve responsiveness. Boards could consider adopting proportionate and integrated approaches to feedback that align with existing processes and priorities, making best use of available information and focusing effort where it will have the greatest impact on learning and improvement. This will help ensure feedback continues to inform shared learning, system improvement and organisational responsiveness, despite resource, time and competing demands.

Boards described several ways in which feedback is used to improve systems and responsiveness. One board reported that some SAERs were triggered by feedback from staff, patients/families, while another board described how actively seeking feedback informs and improve processes. Two boards reported recording feedback in digital systems, such as Datix and Healthcare Guardian. The uses of digital systems can support analysis, learning and improvement activity. Another board indicated exploring the use of Care Opinion to support the collection of patient/family feedback following a SAER. These examples demonstrate emerging practice where feedback is starting to inform system learning and organisational responsiveness to adverse events.

As this work develops, more consistent and person-centred approaches to feedback should help boards show more clearly how views from patients/families and staff are used to improve systems, share learning and strengthen organisational responsiveness.

Next Steps

Next steps will focus on a phased programme of work across 2026/2027. This will begin with publication of the *Learning for improvement: report of the self-evaluation by NHS boards on the implementation of the adverse events framework* to establish a clearer understanding of current practice and variation. This will be followed by targeted work to explore how patient/family and staff feedback is collected, and used, and how learning is identified, shared and embedded in practice. A further focus will be on strengthening the support available to staff to enable sustainable improvement and a culture of continuous learning.

Findings will be shared quarterly with the Scottish Government. HIS will use this intelligence to support national learning and help boards plan, sustain and improve quality. Learning will also be shared through the national learning group to support the spread of effective improvement approaches across NHS Scotland.

Appendix 1

Participating boards

NHS Territorial Boards
NHS Ayrshire & Arran
NHS Borders
NHS Dumfries & Galloway
NHS Fife
NHS Forth Valley
NHS Grampian
NHS Greater Glasgow & Clyde
NHS Highland
NHS Lanarkshire
NHS Lothian
NHS Orkney
NHS Shetland
NHS Tayside
NHS Western Isles

NHS Special Boards
NHS 24
Golden Jubilee National Hospital
Public Services Delivery Scotland
Scottish Ambulance Service
The State Hospital

Appendix 2

The quality checklist is a structured tool within the National Framework that guides and verifies each stage of the adverse event review process, supporting a consistent, quality-driven approach to identifying contributory factors, learning from events and improving patient safety.

Link to the National Framework quality checklist: page 30-31

A National Framework for Reviewing and Learning from Adverse Events in NHS Scotland

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