

NHS Greater Glasgow and Clyde	Paper No. 25/163
Meeting:	NHSGGC Board Meeting
Meeting Date:	18 December 2025
Title:	Significant Adverse Event Reviews (SAER): In-depth Review
Sponsoring Director:	Scott Davidson, Medical Director
Report Author:	Paula Spaven, Director of Clinical and Care Governance Professor Colin Mckay, Deputy Medical Director, Corporate

1. Purpose

This paper presents an in-depth review into NHSGGC's approach to managing Significant Adverse Event Reviews (SAER), with the aim of providing assurance and supporting ongoing learning and improvement.

2. Executive Summary

The paper summarises where we were as a Board and where we are now, highlighting:

- the updated policy and procedure
- significant improvement in SAER performance delivery
- ongoing work to enhance oversight and monitoring, to improve and streamline the SAER process, and to consider resources and support to SAERs
- A review of Clinical Governance arrangements has been commissioned by the Board Medical Director and Director of Corporate Governance

3. Recommendations

Board members are asked to note the updates within this report which is presented for assurance, and ongoing learning and improvement.

4. Response Required

This paper is presented for **assurance**.

5. Impact Assessment

- | | |
|------------------------|------------------------|
| • Better Health | <u>Positive</u> impact |
| • Better Care | <u>Positive</u> impact |
| • Better Value | <u>Neutral</u> impact |
| • Better Workplace | <u>Neutral</u> impact |
| • Equality & Diversity | <u>Neutral</u> impact |
| • Environment | <u>Neutral</u> impact |

6. Engagement & Communications

The issues addressed in this paper were subject to the following engagement and communications activity:

- Corporate Adverse Event Group
- Directors Group
- Divisional Clinical Governance Forum
- Boardwide Clinical Governance Forum
- Clinical and Care Governance Committee

7. Governance Route

The issues addressed in this paper have been considered by the following groups as part of its development:

- CMT - 3 November 2025
- Clinical and Care Governance Committee - 4 December 20225

8. Date Prepared & Issued

Prepared on: 20 November 2025
Issued on: 10 December 2025

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1. Introduction

This paper presents an in-depth review of NHSGGC's approach to managing Significant Adverse Event Reviews (SAER), with the aim of providing assurance and supporting ongoing learning and improvement.

2. Background

NHSGGC maintains a Policy on the Management of Significant Adverse Events. The main aims of the policy are that:

- Clinical adverse events and near-misses are reported and managed in a timely and effective manner in partnership with patients, carers, families and staff
- All people, including staff who are involved in an adverse event are offered support, at a time and in a way which meets their needs
- Feedback is given to staff and will inform decision-making
- Learning from adverse events is identified and used to inform service improvements, that enhance the safety and quality of healthcare provided
- Learning is shared both within and out with NHSGGC to provide opportunities for improvement
- NHSGGC complies with its legal duties in respect of adverse events, including compliance with the statutory organisational Duty of Candour requirements where applicable

3. Assessment

3:1 Where were we

In early 2024, it was recognised that, although progress had been made in reducing the number of adverse events awaiting decision (potentials) and concluding older SAERs in line with agreed improvement targets, further improvement was required. During this period, there was also an increase in complaints concerning SAER timelines and outcomes, as well as an increasing SAER workload.

Accordingly, the Board Medical Director commissioned a review of approaches, policies and practices from other NHS Scotland Boards, to consider alongside the Healthcare Improvement Scotland Adverse Events Framework.

The review found that:

- NHSGGC records a higher average number of SAERs (per capita population) annually compared to other Boards. This may be attributable to differing thresholds for commissioning SAERs and varying levels of adverse event review across NHS Scotland as well as the significant work GGC carries out for other Boards, much of which is complex. Additionally, there was inconsistency across NHS Scotland in the definition of adverse event categories and levels of review.
- Although the HIS Framework specifies guidance timescales for reviews, Boards differ in how these timelines are measured and when the review period commences and concludes.
- Other Boards often coordinate SAERs through a leadership triumvirate—Chief Nurse, Chief Medic, and Area Director —responsible for commissioning, quality assurance, and sign-off of SAERs within their services.
- NHSGGC had a policy of commissioning Level 1 (SAER) review for all organisational duty of Candour (DoC) incidents, whereas other Boards used different levels of review in line with the HIS framework.

The recommendations from the review have been incorporated into the updated policy, procedure and toolkit.

3:2 Where are we now

Updated policy and procedure

The Interim NHSGGC Policy and Procedure for Managing Significant Adverse Events was approved at the Board in June 2025, and was effective from 1st July 2025.

An Interim Policy was required to align NHSGGC with the updated Healthcare Improvement Scotland (HIS) national framework for reviewing and learning from adverse events, which was published in February 2025. The Interim Policy formalized 3 levels of adverse event review within NHSGGC, along with the formation of Adverse Event Oversight Groups (AEOGs).

A separate paper has been submitted to the Board for approval of the full Policy and Procedure.

Significant improvement in SAER Performance Delivery

Figures 1 and 2 below show the significant progress that has been made to complete and close overdue SAERs, and assess potentials.

Figure 1: Number of overdue SAERs

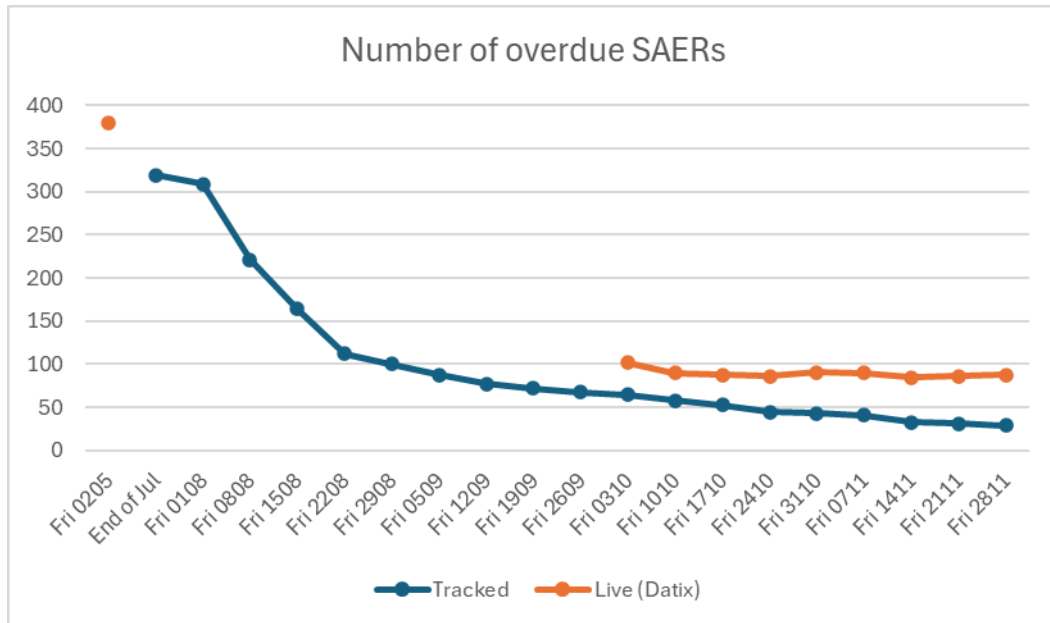
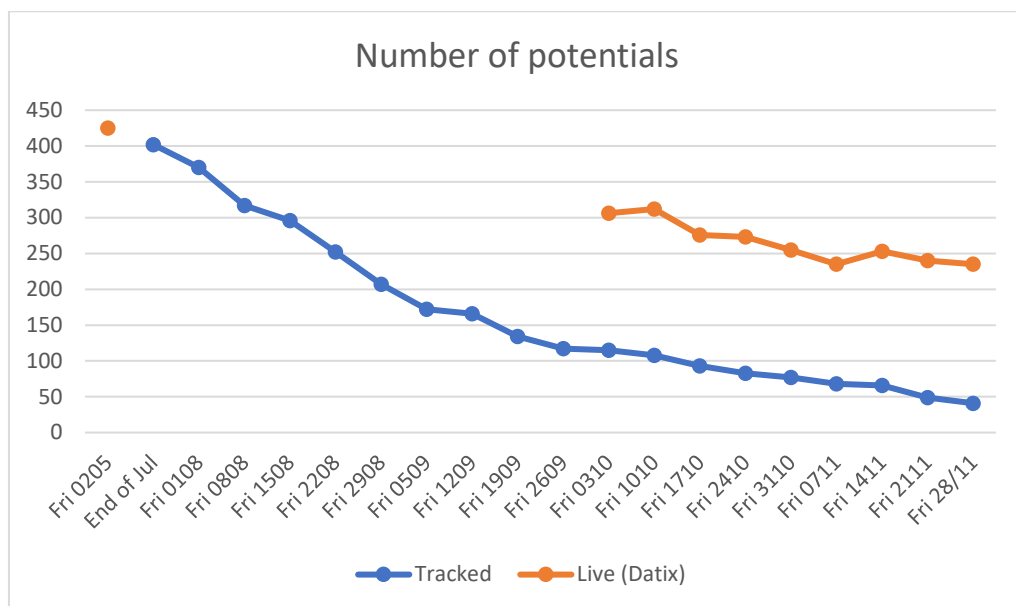


Figure 2: Number of potentials

**these are incidents with a severity 4/5, where an assessment is required to determine the appropriate level of review – Level 1 SAER, Level 2 LAER, Level 3 Incident review – only a small number of these will become SAERs.*



The focussed effort in July resulted in significant reductions in overdue SAERs, particularly in the Acute Division who closed all overdue SAERS from the position at the end of July 2025, but subsequent progress has been slower.

Progress in closing overdue SAERs has been more challenging within the HSCPs where there are often multiple agencies involved, as well as services having quite unique cultures and practices, and limited experience of working together to investigate and change, adding to the complexity of timely investigation.

3:3 Ongoing work

3:3:1 Enhanced oversight and monitoring

Local Adverse Event Oversight Groups (LAEOGs) are now in place across NHSGGC and a formal Corporate Adverse Event Oversight Group (CAEOG) meets fortnightly.

To increase governance and oversight:

- Each Sector (and HSCP) will provide a weekly update on overdue SAERs, requiring an estimated closure date and a responsible manager to be identified. This will be overseen by the LAEOG, supported by a member of the Clinical Risk team.
- A member of the Clinical Risk team will be assigned responsibility for each Sector and HSCP to support the process and escalate to the CAEOG where necessary.

3:3:2 Ongoing work to improve and streamline the SAER process

The SAER Process flow is in place with escalation points active. Further work is required to improve and streamline the overall process:

- Consideration of the threshold for commissioning a SAER and working with national bodies and other organisations to influence criteria for mandatory SAERs.
- Alignment with other review processes to streamline procedures and reduce duplication e.g. existing review processes for falls, pressure ulcers, public protection incidents and infection prevention and control.
- Testing of Co-Pilot to help to produce SAER/LAER reports and learning summaries in a format that is more easily understood by patients and families.
- A review of the extant QA process, which has been commissioned by the Executive Medical Director

3:3:3 Resource and support to SAERs

Discussions with HSCP Chief Officers, Directors, and Governance Leads have identified a lack of resource to carry out timely adverse event reviews, with capacity of front-line clinical staff to undertake reviews a key factor, and a lack of staff available to back-fill any cancelled clinical activity. Enhanced support could be provided through:

- Centralised lead reviewer model - A centralised pool of dedicated, expert Lead Reviewers with allocated time for conducting reviews or providing peer support
- SAER Support team(s) within services – The SAER support team would

provide an effective and efficient support role to review teams, providing a liaison and primary contact role, as well as arranging interviews, minute taking and transcribing of minutes, and completion of draft reports. The resource at a Band 5 level would be apportioned across services based on the average number of SAERS commissioned each year. Based on modelling through the SAER support team that covers Mental Health and Alcohol and Drug Recovery Services within Glasgow City Health and Social Care Partnership, it is estimated that the SAER support staff can individually support up to 8 SAER Review teams each at any one time.

- Centralised clinical risk resource to support SAER project management, SAER performance reporting and assurance, and attend LAEOGs. Clinical Risk Coordinator posts are a Band 6.

3:4 Areas for further consideration

Discussions with HSCP Chief Officers, Directors, and Governance Leads have identified areas of overlap and uncertainty regarding accountability. The distribution of Mental Health reviews across different HSCTs adds to this complexity. A review of Clinical Governance arrangements has been commissioned by the Board Medical Director and Director of Corporate Governance and Terms of Reference should consider the above feedback.

4. Conclusions

This report provides an in-depth review of NHSGGC's approach to managing Significant Adverse Events. Members are asked to note:

- significant progress in reducing the number of overdue SAERs and potentials
- Updated policy and procedure
- Enhanced oversight and monitoring
- Ongoing work to improve and streamline the SAER process
- Consideration of resources and support to SAERs
- Review of clinical governance arrangements

5. Recommendations

Members are asked to note the updates within this report, which is presented for assurance and to support ongoing learning and improvement.

6. Implementation

No implementation is required

7. Evaluation

Ongoing evaluation will be through:

- SAER Dashboard
- SAER KPI reports
- SAER Performance reports to key clinical governance groups, and through Boardwide Clinical Governance Forum and Clinical and care Governance Forum

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- SAER QA assurance processes
- Feedback from patients and families involved in adverse events
- Monitoring of themes from complaints and claims that relate to the SAER policy or approach.

8. Appendices

None