

NHS Greater Glasgow & Clyde



NHS BOARD MEETING

Board Medical Director

Tuesday 16th April 2019

Paper No: 19/21

NHS GG&C Governance & Assurance Mechanisms

Recommendation:-

The Board is asked to note the;

- Range of protocols and processes developed by NHSGG&C to review complaints relating to professional practice.
- Positive feedback provided by the Scottish Government on the issues of surgical safety and M&M reviews at the national event which took place on 4th December 2018.
- Role of the Senior Management Team in providing oversight of complaints/concerns raised including detection of any patterns or themes relating to types of complaints received and/or clinicians involved.
- Range of educational and clinical supervision support of junior medical staff within the NHSGG&C and annual monitoring of trainees through the GMC.

Purpose of Paper:-

Last year events in another NHS Scotland Health Board generated public concern over surgical safety. As part of a national assurance exercise, the Cabinet Secretary for Health and Sport wrote to every NHS Board seeking confirmation of their internal arrangements that ensure prevention, recognition and response to concerns of clinical quality in surgical settings. The attached paper shares with the Board the response provide by NHS GG&C to that inquiry.

Key Issues to be considered:-

There is a detailed description of mechanisms in place within NHS GG&C. The Board actively promotes an open culture in which the processes and procedures described in the attached paper are used to effectively raise concerns, review care and consider trends and learn from any errors. The key issues contained in this paper include:

- Mechanisms to review cluster of complaints.
- Timely decision making and escalation when safety has been raised as a concern from Clinical Directors, Chiefs of Medicine, senior managers and the Medical Director as required.
- Processes to ensure surgical safety including morbidity and mortality reviews at a local level.
- Supervision of junior medical staff and ongoing monitoring.
- Continued development of our culture to promote openness and transparency including development of the NHSGG&C Whistleblowing Policy.

No formal feedback has been provided to the Board. However a national workshop, designed to share best practice, was the source of informal feedback, which commended the response and NHS GG&C staff were asked to lead discussions to share our practices with other NHS Boards.

Any Patient Safety /Patient Experience Issues:-

Any failure of the mechanisms for internal governance and assurance would potentially lead to safety and quality issues for patients and staff.

Any Financial Implications from this Paper:-

No

Any Staffing Implications from this Paper:-

There are staff governance methods described in the mechanisms.

Any Equality Implications from this Paper:-

No

Any Health Inequalities Implications from this Paper:-

No

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:-

No

Highlight the Corporate Plan priorities to which your paper relates:-

The paper relates directly to "Better Care"- Quality and Safety

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Date – 04/04/2019

NHS BOARD GOVERNANCE AND ASSURANCE MECHANISMS

Background

The Cabinet Secretary for Health and Sport wrote to all NHS Boards on 18 September 2018 to “seek assurance on the mechanisms in place for reviewing complaints of professional practice and how Boards are assurance of the safety and quality of surgical practices of its employees.

The letter asked for the response to be structured around key questions. NHS GG&C provided the following response to this inquiry.

NHS GREATER GLASGOW AND CLYDE – SEPTEMBER 2018

NHS COMPLAINTS

1. *Mechanisms for the Board to detect and respond to clusters of complaints about the same clinician – with details of the process and timescales for this.*

When the Board receives a new complaint from a patient or a representative on behalf of the patient, this is logged in a database. Within this database – which is a module on DATIX – there is a section dedicated to ‘Complained Against’. If a complaint is explicitly about the conduct or practice of an individual member of staff, their details will normally be recorded in this section. This means that reports can be generated to ascertain volume of complaints against an individual, and this is used, for example, in the Consultant Appraisal process.

Annual consultant/career grade doctor appraisal requires declaration and discussion of complaints with the appraiser. The Board provides individual clinicians with a summary report of complaints to provide the basis for reflection and discussion. Appraisers are required to note if the complaints have been resolved. Appraisal leads will quality assure the content of the form 4 summary appraisal document and can suggest personal development needs which reflect any training needs. Prior to revalidation there is review of the appraisal record and support is sought from the relevant medical manager for a positive recommendation for revalidation. HIS have audited and reported on the Board’s performance. In July 2018 they were satisfied with the content and achievement rates our return indicated, stating this gave assurance that the appraisal and revalidation process is operating successfully within our organization.

In addition, when a new complaint comes in, it is always shared with the senior management team of the clinical area concerned, and the response must be signed by a senior person, usually a Director or the CEO. This means that senior management teams are fully aware of the volume of complaints they receive, as well as content, so are able to detect any patterns or themes, and deal with these as appropriate.

In terms of responding to complaints, all complaints are handled as per the national Complaints Handling Procedure, and we endeavour to achieve the target timescales for response.

2. *What arrangements are in place for ensuring timely decision making when the safety of practice of a Consultant is raising concern?*

This would be dependent on the nature of a complaint, as all complaints are individual. If a complaint comes in that raises concern about the safety of practice of a Consultant, this would be investigated in line with the aforementioned Complaints Handling Procedure, and if the allegations are serious and upheld, this may trigger a separate process. We have policies and procedures that cover competency and practice issues, and these would be utilised in such a scenario. As described above any clustering of complaints would be identified. If, on receipt of the complaint, there was significant immediate concern, the issue would be escalated to the relevant Chief of Medicine or Clinical Director.

In addition there is a robust Significant Clinical Incident (SCI) process which is utilised when there has been a serious or adverse clinical outcome. This is usually triggered immediately after the event occurs, and involves an intense and thorough investigation into what happened. Whilst the goal of an SCI investigation is not to apportion blame, but instead to identify the root cause of what happened, if issues came to light regarding the practice of an individual clinician, this would be dealt with appropriately and timeously.

SURGICAL SAFETY AND M&M REVIEWS

1. Ensuring that there is reliable delivery of process for pre-operative marking.

The management of safe surgery is a well established clinical quality priority in NHS GG&C. We operate a policy requirement for safe pre-operative marking. This practice is well established and integrates with our policy and practice on consent to treatment, surgical brief/pause and significant clinical incidents, SCIs as noted above.

The nature and side of surgery is discussed with the patient at the pre-op consultant review. This is recorded as part of the clinical note and on the consent form. Pre-operative marking is carried out by the surgeon or nominated member of the surgical team responsible before the patient leaves the ward/admission area. At the time of marking the laterality is checked with the operating list and the consent form and checked verbally with the patient. The presence of the surgical site mark is checked prior to leaving the ward for surgery, crosschecked against the consent form and verbally with the patient. The laterality is subsequently re-checked during the theatre reception process, prior to any anaesthetic blocks and a final check is completed during the "surgical pause" prior to prepping and draping the patient. This is repeated in theatre reception/anaesthetic room. The surgical site mark is checked again at the surgical pause. This process is fully embedded in the pre-operative checklist process. Any discrepancy in the expected procedures or information must be resolved prior to surgery and reported as a clinical incident.

Any incident would be investigated to identify contributory factors then corrective action agreed and monitored through the clinical governance arrangements. Surgery on wrong body part is part of our Board level reports on avoiding serious events monitoring (ASEM reports). There have been no incidents of surgery on the wrong body part to date in 2018. In 2017 there were seven cases investigated only one of which related to a deficit in the pre-operative marking process. The event was not in the main theatres but in a dermatology outpatient clinic. Marking procedures and safety checks were not at the same standards as in the main theatre suites, which has now been resolved.

2. Monitoring workloads, surgical lists length and appropriately equipped theatres.

Operating lists are controlled primarily by consultant staff, although the theatre management system (OPERA) identifies the expected length of common procedures and discrepancies can be

queried in advance with the responsible consultant. Theatre performance data is reviewed at many levels in the organisation with regular reports through local theatre improvement groups, site/sector waiting times, Access meetings and senior management meetings. Ensuring appropriately equipped theatres is jointly the responsibility of medical and management teams, and the responsible surgeon would be expected to be satisfied that appropriate equipment was available prior to the commencement of any surgical procedure. This is checked during the theatre "brief" which takes place at the beginning of each operating list. There is a clear pathway of accountability through the directorate structure for identification of items which require replacement or priorities for capital expenditure.

3. Processes to support clinicians in presenting cases and have time allocated to attend Morbidity and Mortality Reviews.

There are frequent dedicated M&M meetings held within the different surgical subspecialties and data are collected prospectively. Case selection includes all unexpected deaths or deaths from elective surgery, which are subjected to consultant peer review and presented for discussion by the wider group. Each area has a nominated M&M lead who coordinates the process of review. In addition in larger sub-specialties, the quarterly clinical governance meetings are used where specific cases are presented and learning points generated for wider dissemination in an anonymised format.

NHS GG&C has provided evidence based guidance (see attached) and toolkits to support the M&M process. We are also running a long term implementation project to create bespoke data sets for each M&M. These are hosted in the DATIX environment and facilitate standardized data capture, generation of communication and lessons for other services and trend/thematic analysis.

Where the M&M identifies a potential significant clinical incident or duty of candour event these are reviewed with the Clinical Director. The M&M meetings are linked to the clinical governance and medical management arrangements to ensure there is a clear escalation pathway for any emerging concerns.

Consultant staff are job-planned for regular M&M meetings and elective sessions are cancelled for the quarterly joint meetings to support staff attendance.

4. Arrangements for reviewing the effectiveness of on-call rotas.

There is a lead for the Consultant Rota who manages consultant leave and on-call in a fair and effective manner. The on-call and planned activity for emergency work is fully characterised and recorded in consultant job plans. The ability to contact individuals is regularly tested as part of the Major Incident plan. The junior tier rotas (Registrar and FY2/Core trainee) are regularly monitored by the junior medical staffing team to ensure that the working hours and rest time is compliant.

FY1, middle grade and consultant rotas are organised by three different consultant leads. For junior rotas, the priority is to maintain working patterns in keeping with the spirit and the letter of the European Working Time Directive, whilst optimising the opportunities for training. FY1 rotas are supported by experienced Surgical Nurse Practitioners and there are junior and senior tiers of

middle grade supervision on-site 24/7. Consultant cover is provided by 2 consultants providing subspecialty expertise during normal working hours and by one consultant overnight and at weekends. Emergency patients have consultant review, usually twice daily. Consultants are available 24/7 to attend if required. All rotas are reviewed regularly to ensure they adapt to the changing demands of unscheduled care and to both formal and informal feedback from trainees.

SUPERVISION OF JUNIOR MEDICAL STAFF

1. Consultant oversight supervision of junior medical staff.

There is educational and clinical Supervision in place for all junior medical staff.

There is direct consultant supervision of all elective operating and endoscopy lists and there are consultant-led ward rounds 7 days a week. For acute on-call receiving there is a twice daily ward round to review admissions and plan the subsequent trauma operating list. For other patients there is a daily ward round by a consultant or senior trainee.

Trainees undertake most surgical activities in a supervised manner, with the consultant scrubbed assisting, or nearby unscrubbed. There may be some occasions where a senior trainee may undertake a procedure alone that they have been assessed as having full proficiency through the Procedure Based Assessment methodology. This would tend to cover routine trauma operations. It may cover arthroplasty lists in the case of a senior clinical fellow who had achieved their CCT or equivalent.

Trainees are allocated clinical and educational supervisors and supervised according to NES guidelines. The trainee experience in the unit is monitored by annual GMC trainee survey. There is a consultant identified as a lead for junior doctor issues.

OPENNESS AND TRANSPARENCY

1. Description of the processes in place to encourage open reporting and discussion of behaviours not consistent with NHS Scotland Values.

There is an open culture in NHS GGC where the processes and procedures described previously e.g. complaints, M&Ms SCIs are used to effectively raise concerns, review care and consider trends and learn from any errors.

There is a robust Whistle blowing Policy in place which is used effectively by staff within the organization. NHSGG&C is committed to achieving the highest possible standards of service and the highest possible ethical standards in public life in all of its practices. To achieve these ends, it encourages staff to use internal mechanisms for reporting any malpractice or illegal acts or omissions by its staff. The Board wishes to create a working environment which encourages staff to contribute their views on all aspects of patient care and patient services. The Policy describes that Whistleblowing concerns generally relate to patient safety, malpractice, misconduct, wrongdoing or serious risk, and may be something which adversely affects patients, the public, other staff or the organisation itself. Issues covered include;

- patient safety, malpractice or ill treatment of a patient by a member of staff;
- repeated ill treatment of a patient, despite a complaint being made;
- an unacceptable standard of patient/clinical care;

- a criminal offence is believed to have been committed, is being committed or is likely to have been committed;
- suspected fraud;
- disregard for legislation, particularly in relation to health and safety at work;
- the environment has been, or is likely to be, damaged;
- breach of standing financial instructions;
- showing undue favour over a contractual matter or to a job applicant;
- a breach of a code of conduct;
- information on any of the above has been, is being, or is likely to be concealed.

This Policy is available to all staff, including full-time, part-time, temporary, agency and bank workers and ex-staff of NHS GG&C who have concerns about any of the above.

2. How quality of outcomes and monitored and any deficiencies reviewed and necessary action taken.

The clinical and managerial structures, together with robust clinical governance processes in place in GGC support the approach to managing and monitoring clinical outcomes. As described earlier, in terms of structure, issues of concern, be it through the complaints process, SCIs, M&Ms are escalated though to Clinical Directors, Chiefs of Medicine, senior managers and the Medical Director as necessary.

The processes for ensuring sound clinical governance are well established within GGC with recognized fora at Directorate and Sector level up to the Board.