Golden Jubilee Foundation

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18 September 2018

Jeane Freeman MSP
Cabinet Secretary for Health & Sport
Scottish Government
St Andrew's House
Regent House
Edinburgh EH1 3DG

Dear Jeane

NHS BOARDS GOVERNANCE ASSURANCE MECHANISMS

Thank you for your letter dated 5 September regarding NHS Boards Governance Assurance Mechanisms. In responding to the points you have raised I thought it may be helpful to give a general outline of our clinical governance structures within the organisation as these underpin many of the areas you have sought assurances on:

Services are delivered and managed across two clinical divisions, Regional National Medicines and Surgical Services. Each of these has a Divisional Management Team (DMT) comprising of the Associate Medical Director, Associate Director of Operations, Clinical Nurse Manager and AHP lead and a medical Clinical Governance Lead. There are Clinical Governance Leads who are consultants within specialities that have specific roles to support CG activity including complaints and Significant Adverse Events.

There is a Division-wide Clinical Governance (CG) framework; the DMT has oversight of all reported adverse events, clinical incidents and complaints/concerns in a contemporaneous timeframe. The Division has a regular CG committee meeting where patient safety is discussed in addition to other quality measures. This group reports to the Board Clinical Governance Forum via our Clinical Governance and Risk Management Group (CGRMG) with a quarterly risk and safety report and in depth discussion of adverse event and root cause analysis investigations.

Additionally complaints and concerns are highlighted to this group (and the Board) and any specific individual trends are highlighted via the DMT to HR and the Medical Director if necessary.

Please see below my response in relation to the specific questions asked which I have grouped by the overall headings within your letter:

NHS Complaints

There are several mechanisms by which we would identify a cluster of complaints relating to an individual:

- All complaints are co-ordinated via a single point of contact within the Clinical Governance Department that would easily identify such a trend. In addition Medical Clinical Governance Leads and Associate Medical Directors support review of all complaints and again would identify such a cluster.
- As a further support, complaints are logged using the Datix system and clinicians involved are linked as a contact to each individual complaint. At the time of linking the system displays how many other complaints the individual is linked to as a further flag.
- A process is in place to ensure Consultants Appraisers are provided with a report from Clinical Governance department of all complaints consultants have been involved in prior to their annual appraisal.

With regards timely decision making where the safety practice of a Consultant is raising concern, this would be managed via the medical leadership with alert to the Lead Clinician and Associate Medical Director.

Surgical Safety and M&M reviews

All surgical specialities employ surgical site marking in line with best practice, including ophthalmology. Surgical site marking is confirmed at various stages in the pathway including on handover to theatre. Any non compliance with the surgical site marking would be reported as an adverse event. We have no recent reports of patients without any marking in place. We have had some reports where theatre checks have identified inconsistencies in the theatre list and site marked which has been identified at the appropriate check and rectified before proceeding. This confirms our safety checks are appropriate and there is reporting of any non-compliance.

In respect of reviewing effectiveness of on-call rotas, where we can, we separate out on-call from elective work. This is not always possible but depends on the size of rotas and the frequency of emergency calls. In general, the systems work well thus in the elective specialties, it does not present a problem as we are not getting emergency referrals.

In cardiac surgery, cardiology and thoracic surgery, we receive emergency external referrals and we also have a general surgical on-call rota which deals with internally generated emergencies which arise mainly as a complication of cardiac surgery.

In cardiology we have a consultant of the week system which frees a cardiologist during the day time to deal with urgent and emergency patients. There is a similar, although not identical, arrangement for cardiac surgery. General surgical emergency cover overlaps with the same surgeons having elective lists in the hospital. However, this usually works well as cases are short allowing surgeons to fit any urgent consultations between cases. These surgical emergencies are infrequent and almost always 'urgent' as opposed to genuine emergencies. Similarly in thoracic surgery we do not have the resources to free up a consultant thoracic surgeon during the day time just to field emergencies, and urgent day time referrals must sometimes be dealt with between cases. This system is supported by having relatively senior trainees who can provide some flexibility in dealing with phone calls etc.

There are two regular scheduled CME afternoon sessions per month during which elective activity are reduced to allow staff attendance. This time is used for M&M review processes in addition to more general CME. Our main specialities have well established and well attended formal M&M meetings. Attendance at M&Ms is job-planned as a Supporting Professional Activity. The response in relation to outcomes includes reference to the speciality M&M reviews. When there are significant unexpected adverse clinical outcomes or near misses, these are the subject of a formal root cause analysis under our adverse events policy, in addition to being considered at M&M review. Where appropriate we include independent experts (from outwith the Health Board) on our review panels.

Consultant workload is monitored through regular job planning. Surgical list length and issues with equipment and logistics etc are dealt with by the divisional management teams which maintain a close liaison with the clinicians on the ground in addition to formal meeting structures.

Supervision of Junior Medical Staff

There are clear reporting lines to relevant consultants for all junior medical staff both in and out of hours. Most clinical work in the hospital is undertaken either by consultants or with a strong consultant presence. Significant individual instances of failure of supervision or reporting (e.g. patient harm or near miss as a result of a responsible consultant being unavailable out of hours) would be dealt with as an adverse clinical event.

As a postgraduate education provider we are regularly monitored by the GMC. This includes the annual GMC survey of doctors in training which should detect any systematic problem with trainee supervision or support. All the main specialties have an education lead (consultant) reporting to the Director of Medical Education, and we are fully compliant with GMC structures and processes for postgraduate medical training.

Openness and Transparency

We have a very strong values based culture here at Golden Jubilee Foundation and expect all staff to act and behave in a manner consistent with these at all times. We have implemented a programme of Human Factors training with a focus on

communication and behaviours in which we make clear to staff our expectations and also provide them with tools to use in the event they ever have to challenge individuals' behaviour and/ or communication. Any incidences of unacceptable behaviour are reported as adverse events and managed via that process. Additionally, conduct or capability issues highlighted through analysis of complaints or M&M data can trigger our conduct or capability policy as appropriate.

Our conduct policy addresses open reporting and discussion of behaviours not consistent with NHS Scotland values. Key points from the policy are as follows:

- Employees are expected to adhere to acceptable standards of conduct in the course of their employment. Where such standards are not met, a formal process should only be followed where there is no other alternative. In all cases, the primary object must be to assist and support the employee to improve to the required standard. Dismissal on grounds of conduct should only be considered as a last resort.

- In the cases of conduct issues relating to staff groups who require to be professionally registered, the GJF has in place a mechanism to ensure that relevant statutory regulatory bodies are informed, as appropriate, where such issues arise guidance will be provided by the HR team. Employees must be advised in advance of any such referral being made. Decisions in relation to ongoing professional registration as a result of such issues will be for the relevant statutory regulatory body to determine. This policy will, however, apply in relation to those conduct issues in so far as they relate to an individual's employment within the GJF.

- Employees are expected to raise concerns with the appropriate manager where they perceive others not to be adhering to the expected standards of conduct. If an employee felt uncomfortable raising a concern through this route then the Board Whistleblowing policy would be appropriate. Guidance on Whistelblowing is available through the staff intranet.

- Any type of behaviour or conduct at work which falls below the standard required by the GJF or is in breach of GJF policy may be deemed to be a form of misconduct. Where such behaviour or conduct is so serious in itself, or has such serious consequences that the relationship of trust and confidence which is needed between the GJF and an employee has been damaged irreparably, this may be deemed to be a form of gross misconduct.

- It may be necessary, due to the nature of the issues of concern, to remove an employee from certain duties, or to put in place additional supervision in order to mitigate risk, whilst any necessary investigation is undertaken and in advance of agreeing a supported improvement plan. It may ultimately be necessary, in such cases, to place an employee on a short period of paid leave until such times as a supported improvement plan can be agreed and implemented; or the necessary information gathered.

We believe these show a clear process for managing conduct including failure to uphold the values of the organisation is in place.

In considering monitoring of outcomes, all clinicians have personal accountability and personal reflection of activity and outcomes (positive and negative) via the appraisal process. In addition the following describes the processes in places by specialty to monitor quality of outcomes and review and respond to any concerns:

Cardiac Surgery

The Society of Cardiothoracic Surgeons of Great Britain & Ireland (SCTS) and the National Institute of Cardiovascular Outcomes Research (NICOR) are responsible for measuring and benchmarking Unit and individual surgical outcomes for adult heart surgery. This information is published annually on the Societies webpage for clinicians and patients for the preceding 3 financial years. If an outlier is identified either by 'Alert' or more seriously by 'Alarm' the individual surgeon, Audit Lead and the unit Medical Director (MD) are informed and an investigation occurs.

In order to provide an 'early-warning' of surgical performance we continually monitor 'in-house' the Unit and individual surgeon's mortality and morbidity. We hold a monthly multi-disciplinary Morbidity & Mortality meeting (M&M) which occurs on the first Friday of each month in protected CME time in conjunction with Thoracic and Transplant surgery. At this meeting we present the preceding 36 months mortality and significant morbidity for the preceding 60 months by unit, surgeon and procedure. All deaths are reviewed and presented by an independent Consultant Surgeon and Anaesthetist and the level of care graded and passed to Clinical Governance for scrutiny. A Summary of unit and individual surgical mortality is presented to the surgeons and the MD every 3 months. Significant Adverse Event's (SAE's) and Root Cause Analyses (RCA's) are performed where required.

Thoracic Surgery

Deaths and significant complications, including those in whom surgery did not occur, are discussed at the monthly M&M. Deaths are reviewed and presented by an independent Consultant Surgeon and Anaesthetist and the level of care is graded and a summary passed to Clinical Governance for scrutiny. The expected mortality for all procedures performed (using an accepted risk score) versus actual mortality is also presented. SAE's and RCA's are performed where required.

A summary of all thoracic procedures performed in the unit is sent to the SCTS annually and includes death by procedure. Lung cancer outcomes are benchmarked against agreed Scottish National Quality Performance Indicators for lung cancer surgery. This data is collected independently by the West of Scotland Managed Cancer Network and reported back to us. It includes 30 and 90 day mortality, resection rates for stage 1 and 2 and all stage lung cancer as well mediastinal lymph node dissection rates. Each Quality Performance Indicator has a limit to identify outliers. All results are discussed by the Surgeons together as a group and if an individual is found to be an outlier then this would be investigated further and the data presented to the MD.

Ophthalmology

The index complication rate for cataract surgery is the individual surgeon's Posterior Capsule rupture rate. This is recorded via the OPERA system and is reported and reviewed monthly. This has proven successful in identifying practice issues with a new consultant within 4 weeks of operating allowing intervention by the Clinical Lead.

We get outcome data back from Optometrists on all patients. This data is collated by our "head of audit" who gives individual feedback to clinicians and regular reports to the clinical lead. No concerns have been identified to date.

All communications from hospitals elsewhere about our post operative patients presenting to them are copied to our clinical lead. The clinical lead logs any issues of concern and speaks to the clinician involved as necessary.

Any concerns arising through any channel are tabled as a standing item at the monthly consultant meeting and discussed there.

Orthopaedics

The Golden Jubilee Foundation has a large elective arthroplasty with fifteen surgeons performing approximately 25% of the major joint arthroplasty operations in Scotland. The number and type of operations and any complications are submitted to the Scottish Arthroplasty Project. Complication rates by unit and specific surgeon are monitored. Peer review of post operative X rays is embedded in the culture of the orthopaedic department.
The department has job planned M&M and CME meetings.
There is a designated orthopaedic consultant who has clinical governance responsibilities in addition to the operational lead.
These initiatives ensure robust governance arrangements.

Interventional Cardiology including Electrophysiology & Devices

The British Cardiovascular Intervention Society (BCIS) and the National Institute of Cardiovascular Outcomes Research (NICOR) are responsible for measuring and benchmarking both the department and individual cardiologist outcomes for coronary procedures (interventional diagnostic and percutaneous coronary intervention). BCIS audit program publishes information about the practice of interventional cardiology based on assessment of each hospital's activity and performance. This information is published annually on the BCIS webpage for clinicians and patients for the preceding 3 financial years. In view of the nature of the internal M&M and serious adverse event processes any outlying or alarming outcomes are identified in advance of the Society notification. Each Consultant Cardiologist is encouraged to reflect on his/her individual outcomes at annual appraisal. NICOR currently do not externally audit outcomes for electrophysiology (EP) and device implantations. These procedures are subject to internal scrutiny.

All procedures undertaken in the cardiac catheterisation laboratory (coronary, structural heart, EP, SACCS interventions, SPVU diagnostics) are monitored through the interventional cardiology M&M meeting. This meeting is held monthly during protected CME time and has multi-disciplinary attendance. All procedural complications, deaths or significant post-procedure complication (e.g. early acute stent thrombosis, readmission to hospital or stroke) are discussed. Due to the nature of coronary interventions in the acute setting and elective complex interventions in higher risk, elderly and co-morbid populations, approximately 10-15 cases per month are flagged for discussion. Cases are reviewed and presented by an independent Consultant Cardiologist before an open forum discussion to facilitate learning and actions. Significant adverse events and Duty of Candour events are flagged for DMT CG investigation (unless already being undertaken).This process is supported by the CG Department and audit team and outcomes are recorded on the CaTHi database.

Device procedures are not currently subject to the Interventional Cardiology M&M process. Immediate concerns are signalled through the Datix system for adverse event monitoring. There is a rolling complication audit including Heart Rhythm UK standard complications. This is scrutinised by the Divisional CG management team and any necessary actions are flagged with individual operators or clinical lead.

Scottish Adult Congenital Cardiac Service (SACCS)

Deaths or complications in SACCS acute admissions, post-operative care or following cath lab interventions are discussed at a dedicated SACCS MDT forum and reported to CG Leads for both RNM and Surgical Services. Cases are independently discussed, against a standard framework (MDT discussions, pre-procedural planning, peri-procedural care, post-procedure care and communication). Shared learning is disseminated through the SACCS CG forum and with the RNM CG committee.

SNAHFS including Heart Transplant / Mechanical Circulatory Support (MCS)

Heart transplants are registered with NHS Blood Transplant (NHSBT) who mandate outcome returns at 3 and 6 months post–transplant then annually for life including details of mortality and significant morbidity. NHSBT monitors short-term patient outcomes following organ transplantation through centre specific cumulative sum (CUSUM) analyses which compares current outcome rates with an expected rate. Analysis is undertaken monthly for heart transplantation and enable prompt detection of any changes in 30-day mortality rates, provide external assurance and enable centres to compare current outcomes with their own past performance to assist in internal auditing. This data is reported directly to Cardiothoracic Advisory Group (CTAG), NHSBT and each transplant units MD.

All MCS activity is reported through the national NHSBT Ventricular Assist Device (VAD) audit database. This entails detailed data collection and analysis of risk factors and outcomes for VAD implants at all UK centres. NHSBT publishes this data in their annual report on ventricular assist devices for all UK centres. This provides external assurance and enables centres to compare current outcomes with their own past performance and with other centres to assist in internal auditing.

In this unit all mortality and morbidity is discussed at the monthly M&M meeting with consultant led peer-review of cases. All procedure-related and unrelated complications or deaths are discussed in contemporaneous clinical debrief and MDT. All transplantation mortality and specific SAE's are mandated for RCA through Clinical Governance. Shared learning is disseminated through the SNAHFS CG forum and with the RNM CG committee.

Scottish Pulmonary Vascular Unit (SPVU)

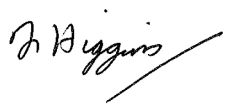
SPVU patients (and clinicians) have shared responsibility between NHS GJF and GG&C. The SPVU M&M meeting is held quarterly within NHS GG&C. Any catheterisation laboratory incidents are flagged for discussion in the interventional cardiology M&M meeting.

Radiology

In addition to the mandatory reporting of radiological incidents through IRMER, the Radiology department has an internal CG forum to highlight adverse events, clinical incidents and discrepancy reporting (through the Royal College of Radiologists framework). Shared learning is disseminated through this forum and with the RNM CG committee

I trust that this information provides you with the assurances sought.

Kind regards,



Dr Mike Higgins
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