NHS Ayrshire and Arran

NHS COMPLAINTS
• **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**

Complaints are saved to a database with a key word field used to list all named individuals which allows subsequent searches for complaints relating to individual clinicians. Complaints about a clinician are sent by the complaints department to the relevant general manager and clinical director, who are well placed to identify clusters, and to triangulate with other sources of information such as clinical incident reports. The clinical director and general manager would receive these complaints from the complaints department within days. All complaints investigations about individual clinicians are reviewed by the clinical director to ensure a fair and consistent investigation has taken place. The complaint handling process sets out the timescales for investigation – 20 working days for Stage 2 complaints. Complaints are discussed as part of each department's monthly clinical governance meetings. These meetings are multidisciplinary and give a further opportunity for peer challenge.

A weekly report containing detailed information on current complaint activity is shared with all members of the senior team, including associate medical directors, which allow for monitoring of complaints against individuals. The QI Lead for Customer Care has an overview of all complaint activity and reviews the weekly reports for any recurring themes that may raise concerns about safe practice. She communicates directly with the appropriate associate medical director and senior manager where concerns are raised about individuals.

Each department also provides a complaints report to the bimonthly Hospital Clinical Governance Committee co-chaired by an associate medical director and associate nurse director. Significant complaints would be expected to be highlighted, giving an opportunity for further oversight.

The complaints department also provides an annual summary of complaints to each clinician for appraisal purposes. This gives clinicians a chance to reflect on their own practice, and to request support if required. If the appraiser had sufficient concerns about patient safety, the appraiser is obliged to breach the confidentiality of the appraisal process and report the concern.

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

If a consultant's practice is raising patient safety concerns, the clinical director is expected to discuss these issues with their associate medical director promptly. The associate medical director, having understood the issues, and made any further brief enquires felt necessary, would inform the board's medical director, who would then decide promptly on the need for any action which might include observed practice, re-training, suspension of specific procedures or groups of procedures or full non-judgemental suspension of the clinician. Such processes normally take a matter of days following escalation to the associate medical director. These processes would be taken in line with human resources policies on conduct and capability, and would involve advice from the human resources department. Our aim is to prioritise patients' safety while also respecting the rights of the employee.

SURGICAL SAFETY AND M&M REVIEWS

- **Ensuring that there reliable delivery of process for pre-operative marking**

Our consent policy and procedures require pre-operative marking to take place before leaving the ward or day surgery unit. The surgeon is required to verify correct site against radiological imaging where appropriate, and to confirm with the patient before sedation is administered. A pre-operative checklist is completed by the ward nurse then the theatre reception nurse before leaving the ward, and finally by the theatre nurse before leaving the reception area. All three are required to confirm that pre-operative marking has been done (where relevant), and the patient is not allowed to proceed to the next stage of their pathway if it has not been completed. Our nurses have been empowered to challenge surgeons if this is not the case, and to require the surgeon's return to the ward.

There is a surgical huddle in the theatre before each surgical operative list begins, attended as a minimum by the surgeon, anaesthetist and theatre nurse. Confirmation of pre-operative marking is confirmed at this point, and if appropriate verified against radiological imaging in the theatre. Audits have been performed to confirm these procedures are being followed.

- **Monitoring workloads, surgical list length and appropriately equipped theatres**

On both acute hospital sites there are weekly theatre meetings with clinical nurse manager, general manager and clinical directors to review the use of theatres, using data generated from the Opera theatre reporting system. Late starts, early and late finishes would be identified routinely as part of these meetings, and if there was a recurrent with a specific operator this would be investigated by the clinical director.

Required theatre equipment should be identified at the morning theatre huddle. We are implementing debrief sessions at the end of theatre

lists, which also provide an opportunity to capture issues about equipment. Finally, if an equipment issue was felt to be significant it would be reported through the Datix system and reviewed as part of normal clinical governance procedures.

- **Processes to support clinicians in presenting cases and have time allocated to attend Morbidity and Mortality Reviews**

Every month an audit day is held for surgical and anaesthetic teams. All theatre activity is cancelled on those days to maximise attendance. Mortality and morbidity reviews are held as part of those meetings. Combined cross specialty sessions are also part of these days.

We are piloting an approach to improve team involvement, promote the learning culture and education for trainees and record centrally a useful structured based approach to mortality and morbidity reviews. This will be trialled within the Datix system and will be used alongside the robust and regular mortality and morbidity meetings. These structured outcome notes can then be fed into normal clinical governance process.

- **Arrangements for reviewing the effectiveness of on-call rotas**

On-call arrangements for consultant staff are part of annual job plan reviews, and the rota would normally be discussed at least annually by the department as a whole. Concerns about the on-call rota could be raised within the team at any time, and on-call rotas may be restructured accordingly. Trainee rotas are designed to be compliant with the European Working Time Directive and the board has used the Professional Compliance Analysis Tool developed by Scottish Government to support development of rotas that are commensurate with the goals of safety, patient-centred care, high quality training and doctors' health and wellbeing.

If nursing staff had concerns about the on-call rota (e.g. inability to contact the on-call consultant) they can escalate via nursing or medical management. If junior doctors had concerns about the effectiveness of the consultant on-call rota, or indeed their own rota, they can report this to the clinical director or to their clinical or educational supervisor or to the associate director of medical education, if they wish to speak to someone external to the department.

SUPERVISION OF JUNIOR MEDICAL STAFF

- **Consultant oversight supervision of junior medical staff**

All junior medical staff have a named consultant educational and clinical supervisor. During normal working hours junior doctors will be supervised on ward rounds and in theatre, with independent practice delegated according to the supervising consultant's confidence in their abilities. Out of hours, all junior doctors are supervised by an on-call consultant. While normally resident at home, the consultant is expected to attend if the situation requires their skills, or if the junior requests attendance. If junior doctors are unhappy with the degree of supervision being

provided they can report this to the clinical director or to their clinical or educational supervisor or to the associate director of medical education, if they wish to speak to someone external to the department.

OPENESS AND TRANSPARENCY

- **A description of the processes in place to encourage open reporting and discussion of behaviours not consistent with NHSScotland values**

Our Board put considerable efforts into developing the local culture and values, developing the values from the ground up with extensive staff consultation. Our Board's values are Caring, Safe, Respectful. All staff are empowered to challenge behaviours that deviate from those values.

As part of our clinical governance processes we have emphasised a quality improvement approach, to help us become a truly learning organisation. It is staff's experiences of our approaches to investigating complaints and incidents that will demonstrate to them that we are focussed on improvement rather than blame, which in turn encourages further open reporting.

Junior doctors have been involved in training sessions to enhance their knowledge of the organisations reporting system for adverse events. This includes discussion around what an adverse event is, how to report and what their expectations are and how these correlate to the board's commitment to being a learning organisation. A new learnPro (e-learning) 'Reporter' package has been developed and will be rolled out to all staff. The course will cover the key information for reporting adverse events using the electronic reporting system (Datix). This will be further supported by a Chief Executive Note which will be cascaded to all staff within the organisation. For our medical, nursing and general managers we have provided root cause analysis training, which emphasises a systems approach to learning from errors. We also provide regular short quality improvement training courses for all staff who wish to attend.

Given our values and culture, we would expect our staff to be able to raise concerns within their own teams, or to escalate them to more senior managers if necessary. However, should that fail, the board has a Whistleblowing Policy which identifies the medical director, nursing director, finance director and human resources director as contacts for reporting concerns. The policy also identifies that concerns may be raised with the chief executive, or with the Scottish Government Health Directorates. The board has a non-executive director identified as whistleblowing champion.

We are working in conjunction with NHS Lothian to pilot the Being Open process within our maternity unit; progress of this work will be shared with the Scottish Government as the collaborative work progresses.

- **How quality of outcomes are monitored and any deficiencies reviewed and necessary action taken**

Routine monitoring of quality of outcomes varies by procedure and specialty. Some specialties or conditions have nationally or regionally agreed approaches to measuring and benchmarking outcomes but this is not standard across all surgical procedures.

In cancer surgery, the regional cancer network has nationally agreed quality performance indicators against which the board's performance is monitored. From a surgical perspective these might include achievement of specific resection margins, 30 day survival or longer term survival. Where a board's performance is an outlier, the regional network will request an action plan from the relevant department and escalate to the board's medical director.

Trauma and orthopaedic surgery is also monitored in a variety of ways. Surgical site infections after hip or knee arthroplasty are collected and reported in a standardised way as part of the board's HAIRT report. The Scottish Arthroplasty Audit collects and benchmarks data following hip and knee arthroplasty. The clinical team collect patient relevant outcomes following hip and knee arthroplasty and these are monitored within the department. The Scottish Hip Fracture Audit collects standardised data and benchmarks against other Scottish units. The national audits have similar governance structures to the cancer networks with outliers reported to boards and action plans requested.

For other benign surgical procedures, unsupported by regional or national networks, monitoring of outcomes is managed in a less systematic way. We believe that this would benefit from a national programme supported by ISD. Increasingly, appropriate outcome measures are being developed by international organisations such as ICHOM. The emphasis on patient relevant outcomes is welcome, and would align well with shared decision making and Realistic Medicine. While individual boards could develop this, it would be far more effective as a national or regional programme.

Where there has been a specific adverse outcome, any member of staff can report this through the Datix system. We have reviewed and improved the management of adverse events through development of our policy, most recently updated in May 2018. Adverse events are monitored at multiple levels in our governance processes. All events are reviewed at ward/departmental level. A weekly report also goes to an Adverse Event Review Groups (AERG) for events reported in the preceding week. The group scrutinise this to determine whether further information or review is required. Adverse events graded consequence 4 or 5, or where Duty of Candour requirements are relevant, require completion of an Adverse Event Review Level Decision Making Form to assist the group to determine what level of review is appropriate. Where Duty of Candour applies, a minimum of a Local Management Team Review (LMTR) will be undertaken. Adverse Event Review Level Decision Making Forms are escalated to the executive sponsor (medical and nurse directors) to agree and commission LMTRs or Significant Adverse Event Analysis and Reviews (SAERs). A fortnightly update is presented to the chief executive, medical and nurse directors, and assistant director for occupational health, safety and risk management to track progress of the SAERs and status of action plans. LMTRs and subsequent action plans are monitored and reviewed through the AERG. Quarterly progress is presented to the Risk Management Committee on the management of adverse events. A report is provided to the board's Healthcare Governance Committee with a summary of the number of reviews being undertaken for each level of review.

One issue with identifying poor outcomes for individual surgeons is that serious complications are relatively rare, and clusters can occur by

statistical chance. This is particularly an issue for surgeons performing high risk surgery. With assistance from Scottish Government, we previously investigated an electronic reporting system based on the POSSUM risk adjustment score for surgical procedures (CRAB-POSSUM). This used routine SMR data to generate monthly and annual reports on the complication and mortality rates for individual surgeons. Monthly reports were shared with the surgeon allowing data to be verified. The intention was that this would highlight at an early stage any statistically significant deviations from normal, allowing for early corrective actions. Unfortunately, data quality prevented this system from being useful. Data quality has generally improved since that time, however, and ISD may find such approaches worth revisiting.