NHS Complaints

In your letter you asked about the mechanisms we have in place in NHS Highland to detect and respond to clusters of complaints about the same clinician and the systems to ensure timely decision making when the safety of a Consultant is raising a concern. I wish to confirm that in NHS Highland we have robust systems in place to identify and act upon concerns relating to complaints raised about clinicians.

All completed complaints investigations are screened by the Clinical Governance Support Team (CGST) for doctor involvement and any doctors subject to complaint and/or found to be directly involved in the care complained about are linked to the complaint investigation. The CGST provide all doctors with a report annually, detailing complaints, SAERs and litigation that they are linked to to discuss in their appraisal.

The CGST also run a quarterly report to identify any doctors who have three or more complaints linked to them in the preceding 12 months. For any doctor who reaches this trigger, a report is sent to the relevant Associate Medical Director (AMD) to review the content and patterns in the complaints. The AMD then discusses their findings in the quarterly Secondary Care PAR meeting (Performance, Appraisal and Revalidation) and action is taken as agreed in this meeting.

The complaints history of each doctor is also considered when confirming revalidation status.

The above describes the formal systems in place. In addition to this, a manager in the CGST undertakes a final quality assurance of all complaint responses and can interrogate the Datix system if concerns are raised regarding an individual. Such concerns can (and are) highlighted to the Board Medical Director and AMDs as soon as these concerns come to light.

Surgical Safety and M&M Reviews

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

Pre-operative marking should be completed on either the ward or common admission area prior to arrival at the theatre suite. Site marking is embedded in the surgical pause process and checked at theatre reception. Patients would not pass further than theatre reception without confirmation of site marking. A final safety check for marking is included in the peri-operative documentation where the absence of marking would be highlighted as a risk to be resolved before proceeding to the next stage.

- Monitoring workloads, surgical list length and appropriately equipped theatres

The theatre coordinator has a key role in this area. The appropriateness of list booking is sense checked, largely through experience, but also by reference to historical OPCS data to guide procedure length where needed. Overbooked lists are identified and action taken - either to reduce the list size or to accommodate work in other theatres. Standard procedure is not to allow overunning of lists and is one reason why some cases get cancelled late in the day if progress has been unexpectedly slow. Theatre start times are a useful measure of workload in that practitioners who are overburdened might arrive late and delay the starting time. These metrics are monitored routinely and action taken to address late starts on an individual basis when required.

- Process to support clinicians in presenting cases and have time allocated to attend Morbidity & Mortality Reviews

A monthly surgical M&M meeting takes place with formal presentation of cases followed by discussion and electronic recording of conclusions and learning points. There is a close link with hospital clinical governance processes whereby formal review of cases can be instructed if a concern is identified with written output from the M&M meeting then submitted to the hospital Quality & Patient Safety Subgroup for further consideration and potential action. Concerns can be identified from a variety of sources including the hospital mortality review process, CPR case review process, adverse events, complaints or concerns from individual clinicians. Time for clinicians to attend these meetings is included in job plans and elective activity is cancelled on 10 afternoons per year across the hospital to facilitate engagement and attendance at these meetings.

- Arrangements for reviewing the effectiveness of on-call rotas

Junior doctor rotas are monitored against agreed templates to ensure compliance. Consultant rotas are constructed to avoid double running with elective activity so that roles are clear and independent with adequate time to rest after shifts.

Supervision of Junior Medical Staff

Within NHS Highland we are compliant with the GMC standards – Promoting excellence in Medical Education and Training 2016 (https://www.gmc-uk.org/-/media/documents/promoting-excellence-standards-for-medical-education-and-training-0715_pdf-61939165.pdf)

All of our junior medical staff have a named clinical and educational supervisor- all of the clinical and educational supervisors are selected, trained for the role and have time to deliver.

At induction all junior medical staff are informed of routes to highlight concerns- either via the clinical /educational supervisor or if their concern is with that individual through the management structure in the directorate in which they work or to escalate directly to the medical education directorate.
Junior medical staff are also supported via the NES Training Programme Director/Associate Post Graduate dean structure and are also encouraged by them to escalate concerns.

Openness and Transparency

NHS Highland have HR policies in place such as whistleblowing policy and Preventing Bullying and Harassment which enables staff to raise concerns about practice and behaviours in the workplace and that we encourage staff at all levels to raise any concerns they may have at the earliest opportunity. All staff must complete statutory and mandatory training for their role which includes a module on Equality.