Letter by Email to:
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Cabinet Secretary for Health and Sport
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Date: 18 September 2018
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Dear Cabinet Secretary

NHS BOARDS GOVERNANCE ASSURANCE MECHANISMS

Thank you for your letter of 5 September 2018. On behalf of NHS Lanarkshire, the information requested on the mechanisms in place are outlined below.

NHS Complaints
NHS Lanarkshire's complaints handling procedure reflects our firm commitment to welcoming all forms of feedback, including complaints, and using them to improve services. Our complaints handling procedure is based on the model developed by NHS complaints handling experts working closely with the Scottish Public Services Ombudsman (SPSO).

The General Medical Council's education standards set out the requirements of NHS bodies and primary care providers in terms of the organisation and provision of medical education and training. It places a particular emphasis on the need for the learning environment and organisational culture to value and support education and training, so that trainees are able to demonstrate the responsibilities, values, behaviours and learning outcomes required. For career grade doctors, we ensure appraisers place emphasis on the role of learning from complaints in individual appraisals and identify where appraisees can develop or change their approach to improve patient care.

All complaints relating to medical staff are read by the Hospital Chief of Medicine and also by the Clinical Director responsible for the individual doctor(s) involved. This means that patterns in relation to complaints can be detected. Complaint responses and decisions on upheld / not upheld are fed back to relevant medical staff and their line managers. Our experience has been that the patterns identified are usually as a result of failure in communication between doctor and patient. However, medical managers will also be aware of any recurrent issues suggestive of poor practice.

The numbers and types of complaints relating to individual medical staff are monitored via the annual medical appraisal process. The organisation's appraisal co-ordinator requests a summary of complaints per individual in advance of medical appraisals, and this is provided by the Corporate Complaints team. Currently this information is provided to the appraisee, not the appraiser, so relies on disclosure by the individual at the time of their appraisal meeting. However, all our appraisers expect to see and discuss this and if a clinician was to

withhold relevant information from their appraiser this would have serious consequences for them as all appraisees sign off a statement regarding their probity annually.

With the current DATIX system for handing complaints, there is reliance on the staff recording the complaint being able to identify and record the correct individual. On occasion a clinician may be identified who has not been directly complained about or indeed been involved in helping to respond to concerns before the complaint was made.

We are in the process of reviewing our recording and reporting systems, to enable us to gather improved thematic complaint information. This will identify recurring themes by location and staff. We are also exploring the concept of setting triggers for automatic escalation of complaints to the relevant medical manager.

The arrangements in place to identify unsafe practice rely on effective team work by the hospital management team on each site supported by colleagues from Human Resources. Identification of potential problems and acquiring the necessary evidence can be a complex and time consuming process frequently requiring investigation and repeat investigation. Significant adverse events involving doctors are identified through the DATIX system and Significant Adverse Event Reviews are commissioned by Medical and Nurse Directors in Acute Services or in our two Health and Social Care Partnerships. If serious concerns arose about a clinician's practice, urgent discussions would take place between the CD involved, the site Chief of Medicine and the relevant Medical Director and a decision would be taken to invoke appropriate interventions in order to protect patients and, indeed, the doctor themselves.

Surgical Safety and M&M Reviews

- **Pre-operative marking**
  There are robust safety mechanisms in line with WHO surgical safety checklist and implementation guidance as part of the 10 Patient Safety Essentials. Surgical briefs and pauses are the processes that provide assurance, with the completion of a surgical checklist and acting as a final reminder of items that must be completed prior to commencement of the operation. In addition, the Sign-out underpins patient safety in theatre and provides a reporting mechanism for adverse events through the post theatre brief.

- **Monitoring workload, surgical list length and equipment**
  Using the Theatre Management System (Opera), effective usage of theatre time is monitored and cases listed with the appropriate amount of theatre time to reduce over booking, over runs and help manage workload effectively.

- **Morbidity and Mortality Reviews**
  Morbidity and Mortality (M&M) Reviews are considered mandatory and we ask for evidence of attendance at job plan reviews. Time for M&M is included within SPA allocation to consultants. Supporting clinicians in this, is done by the site M&M leads who have time in their job plan.

  All departments have operated a system of review for Morbidity and Mortality. Recently this has included review of all deaths collated by the M&M lead removing the voluntary reporting seen previously. Peer review of cases selects those "unexpected" deaths for discussion at M&M meetings. These meetings are intended to be multidisciplinary. Morbidity is harder to capture and relies on voluntary reporting by members of the unit

although systems are in place for anyone to record any ones' morbidity in an anonymous post box fashion. Issues are then reported up the directorate structure.

M&M's are frequently joint meetings with clinically related departments sharing perspectives and helping to avoid professional biases. Hospital wide M&M's are now routine with the opportunity for wider learning of all staff groups. Chief Residents have also supported mini M&M's to allow doctors in training to discuss issues of interest and learning.

- **Effectiveness of on-call rotas**
  Effectiveness of on call rotas is harder to evidence. A culture of reporting with patient safety in mind responds to issues allowing review of working practices. Monitoring of junior doctors hours ensures safe workloads and Clinical Directors work directly with Human Resources to ensure rota templates are compliant with European Working Time Directive etc. We increasingly use the Professional Compliance Analysis Tool (PCAT) tool to co-design rotas with trainee medical staff.

Supervision of Junior Medical Staff

There is always a named, contactable consultant on call for each hospital site. In addition there are Middle-grade staff who are present at all times at each hospital site.

Each hospital carries out regular ward rounds including daily board rounds and, usually twice daily on all emergency patients 7 days per week. There are also regular handovers and huddles, all of which include junior medical staff and many of these are led by the on call consultant. An escalation tool called RESPOND has been developed in one hospital to support staff escalating concerns at any level, encouraging them to recognise that consultant input should be the expected norm when 'red flag' symptoms are present.

Openness and Transparency

- **Reporting and discussion of behaviours not consistent with NHS Scotland values**
  One of NHS Lanarkshire's safety ambitions is to develop a sustainable safety culture. This culture requires honesty, transparency and being open with staff, patients, carers and relatives. Achieving a culture of safety is a challenging ambition and a long term aim requiring an on-going commitment to be able to learn from harm and error and demonstrate the implementation of changes and improvement. As part of our work to improve the safety culture, we are focusing on ensuring our staff feel psychologically safe. We are currently testing a psychological safety questionnaire with Nurses, Midwives and AHPs with a view to rolling this out across the organisation.

  In the majority of cases, the causes of adverse events or near misses go far beyond the actions of individuals immediately involved. In healthcare, there are a number of factors at work at any one time that can affect the likelihood of adverse events occurring. It is with this in mind that NHS Lanarkshire is committed to advocating an 'Open and Fair' culture. A culture where errors or service failures can be reported and discussed, lessons learned and necessary changes put in place is essential.

  NHS Lanarkshire has in place, an adverse event reporting and recording system that will support good practice and compliance with legal duties from a range of bodies including Healthcare Improvement Scotland (HIS), and the Health & Safety Executive (HSE). NHS Lanarkshire uses the DATIX electronic risk management system for recording and grading clinical and non-clinical incidents.

Within one of our acute hospital sites the Clinical Director for Surgery has developed a "black box data recorder" in our surgical unit aimed at juniors who perhaps are unfamiliar with the DATIX system to encourage reporting of safety and training issues.

If there are instances where individuals must be held accountable for their actions this is managed through the Board's agreed Human Resources (HR) policies and procedures.

NHS Lanarkshire follows the Duty of Candour procedures which are designed to ensure that organisations are open, honest and supportive when there is an unexpected or unintended incident resulting in harm or death.

- **Monitoring outcomes**
  Outcomes are monitored through a range of different mechanisms including:
  - Multidisciplinary Team (MDT) reviews
  - M&M Reviews
  - Monitoring of readmission rates and 30-day mortality.
  - Local and national clinical audits such as:
    - Cancer Quality Performance Indicators (QPIs)
    - Arthroplasty Register, Hip Fracture Audit and STAG
    - Vascular Registry
    - Renal Registry
    - Stroke Bundle audits
    - Interventional cardiology – via British Cardiovascular Intervention Society
    - Urology – via British Association of Urological Surgeons
    - Scottish Intensive Care Society Audit Group (SICSAG)
    - Endoscopy audits

All of these mechanisms are reviewed locally by a clinical lead and presented for assurance via the formal clinical governance meetings.

I trust the above information is helpful.

Yours sincerely

Calum Campbell
Chief Executive