

COLLABORATION WITH THE SCOTTISH HIP FRACTURE AUDIT

The Scottish Hip Fracture Audit (SHFA) has been in existence since 1993 and representatives from each body (SHFA and SASM) are now invited to their respective steering group meetings. The SHFA produces monthly "real time" reports to enable each hospital to monitor their performance in relation to national targets and also produce an Annual Report, which can be accessed at www.show.scot.nhs.uk/shfa. SHFA examines specific areas within the process of care of the hip fracture patient using Sprint Audits which are subject-specific short-term audits. The next Sprint Audit will look at patients deemed "medically unfit" for theatre and an audit form is being developed to capture this information. This Sprint Audit is due to start in January 2007 and will be dependent on the co-operation of anaesthetists who manage these patients. The SHFA local co-ordinators in each participating centre will keep you up to date with the progress of the project and your support would be appreciated and would optimise the accuracy of the data collected.

There are also opportunities for individuals, or groups of individuals who are interested in interrogating the database that has accumulated information over seven years on anaesthetic techniques. This work could link with the Outcomes Group of the SHFA. Anaesthetists with interests in this area of care, who would like to comment or contribute, should contact Kathleen Duncan, the SHFA Co-ordinator at Kathleen.Duncan@lanarkshire.scot.nhs.uk with their views.

Freedom of Information

There appears to be confusion about the release of SASM data under the FOI Scotland Act (FOISA). The SASM data which was released by ISD earlier this year, in response to a FOI request by the press, was the identity of surgeons with low compliance (less than 85%). ISD's assessment of the request was that the information was held by SASM and there were no grounds for exemption under FOISA. At about the same time, ISD, under instruction from the Scottish Information Commissioner following ISD's original refusal to release information to the press, published information (SMR01 based) about deaths attributed to each surgeon in Scotland. This has led to the two responses being linked by some surgeons, which they are not.

The Commissioner stated quite clearly in his article in the last newsletter that he "made a point in distinguishing between...routinely gathered information (SMR01) and the information which is provided as part of the Scottish Audit of Surgical Mortality." He further went on to say that he concluded that the surgical audit process would be covered by an exemption and information about an individual surgeon would be highly unlikely to be released in response to any request for such information.

In the same issue of the newsletter, Professor Sir Graham Teasdale, Chairman of the Board of SASM also commented on the limitations of the information released on the ISD website and drew attention to the difference between release of SMR01 information and the confidentiality of clinical audit. If any surgeons still have concerns relating

to the information which they give to the audit, please feel free to discuss this with their local surgical co-ordinator who is contactable via the SASM offices.

Using the database - the SASM Research Group

This new initiative is chaired by Alastair Thompson, Deputy Chairman of SASM and is intended to promote the analysis of SASM data in context and to present findings to the wider health community. It is hoped that individuals propose specific projects looking into aspects of SASM data or issues which are raised by the Board, Management Committee or the Liaison Group are examined. Individuals wishing to put forward projects for consideration would be expected to develop a single side A4 sheet outlining the proposal and would also be expected to present any resulting findings. For further information, please contact Alastair Thompson at a.m.thompson@dundee.ac.uk.



Individual Annual Reports

Individual annual reports have been sent to general surgeons, orthopaedic surgeons, urologists, gynaecologists and neurosurgeons. Reports for surgeons in other specialties, and for anaesthetists, will be sent out by September. Initial feedback from the general surgeons was very positive with most surgeons welcoming the addition to their appraisal folder and the feedback it provides. Issues which were raised included identifying cases which are still undergoing assessment and a note to this effect has been incorporated into the other specialty reports. Other concerns relate to clarity of explanation of areas for consideration or concern and the difficulty of attributing the care of a patient to any one clinician.

Individuals may consider requesting a team report rather than an individual report in future.

The publication of the reports has also provoked comments by clinicians as to the accuracy of the data and these are currently being investigated by SASM to ensure that the quality of the data is high. There is also some confusion about patients admitted under the care of surgeons who do not undergo operation. The protocol which SASM uses is "death under the care of a surgeon, whether or not an operation has taken place". If you have any further comments, please contact Helen Burton at helen.burton@isd.csa.scot.nhs.uk.

Slow returns to Intensive Care initiative

The first forms completed by intensivists have been received by the SASM offices but numbers are lower than anticipated. Presently all surgical patients who have been admitted to intensive care in four hospitals, Edinburgh Royal Infirmary, the Western General Hospital, Edinburgh, Glasgow Royal Infirmary and the Western Infirmary, Glasgow, should have

the intensive care form forwarded to the Intensive Care Unit for completion even if they were discharged from the ITU. If you are having difficulty in obtaining notes or forms, please contact the SASM office for advice. Both SICSAG and SASM will be investigating the reasons behind the low return rate before rolling the programme out further.

SURGICAL PROFILES

NHS QIS is in the process of producing Health Board level surgical profiles using some cumulated, not individual, mortality data from SASM as well as data from other sources. These profiles are expected to go to Health Boards in

October with responses from the Health Boards by February 2007. Some of this information is likely to go into the public domain later in 2007, but it is stressed that this is not individual data but data for each Health Board.

Changing Patterns of Care

In the Annual Report for 2004, it was noted that the number of surgical deaths had dropped to an all time low. As a result of initial collaboration between SASM and the Scottish Hip Fracture Audit, the discrepancy could be partly explained by the increased proportion of hip fracture patients who are rapidly discharged after surgery from acute orthopaedic wards to nursing homes and other care providers.

As the quality of care to end of life patients, particularly in orthopaedics and vascular surgery, was also identified as cause for dissatisfaction by consultants in the 2004 Annual Report, it is possible that this shift from acute care will increase over the next few years.

At present, the Management Committee is expecting a statistical report for consideration about the volumes of such cases that can be identified through linkage of hospital discharge records and death registrations. This will inform the Committee's debate on the issue of whether the SASM definition of a 'death under the care of a surgeon' needs to be reconsidered.

YOUR VIEWS ON CLINICAL GOVERNANCE AND THE AUDIT

SASM has grown from an educational audit to having potential roles in patient safety, quality assurance and appraisal. In other national audits, to which many in SASM contribute there are now robust, clear and unambiguous systems in place to manage individuals who are outwith normal variation. In the Scottish Arthroplasty Audit at www.arthro.scot.nhs.uk/index.html under "Clinical Governance" there are flow charts detailing the process for surgeons and Health Boards outwith normal variation, which remains confidential. The Vascular Society has a similar system which can be looked at on www.vascularsociety.org/committees/audit.asp#nvd.info also under the Clinical Governance tag.

Within SASM, in the past, concerns which have been raised within the

audit about the performance of a handful of doctors have been locally resolved maintaining confidentiality. However, the GMC has recently published guidance (1) for individual doctors, which would apply to the doctors on the Board and the Management Committee for referring other doctors to the GMC. Unlike the Arthroplasty audit or the Vascular Society database, SASM cannot identify "outliers" and merely identifies rare individual cases or clusters of cases where potentially serious concerns may have been expressed by peer group review. NCEPOD, dealing with similar cases, although with more limited participation and in greater detail, has created a "Cause for Concern" policy, in which, if a case causes particular concern, the Chief Executive breaks the anonymity of the case and writes to the Medical Director of the hospital

using a standard letter and asking them to review the case locally.

SASM is very aware that the potential of these very few cases and their method of handling them provokes great anxiety amongst some of the profession and are eager to learn how the profession in Scotland would like to address these issues particularly in respect of what merits concern, who to notify and when to notify that concern and the protection of confidentiality. To that end SASM has produced a discussion document, shortly to become available on the website, and would welcome views on the content of this document addressed to Dr Nick Pace, Chairman of the Management Committee at the SASM offices in Glasgow. Please contact sasm@isd.csa.scot.nhs.uk

(1) Referring a Doctor to the GMC: A guide for individual doctors, medical directors and clinical governance managers. GMC 2006

Returns for 2005 Cases

Some of you will have been involved in the discussions at the end of last year when, under the Freedom of Information Act, journalists from the Glasgow Herald and the Scotsman requested the names of the individual surgeons who had not returned any completed forms or who had more than 10 forms not returned in the 2004 data.

In the event, only three surgeons were identified as, in several cases, patients had been misattributed, surgeons misidentified and completed forms received after publication of the Annual Report. These late returns, although not part of the Annual Report, will be part of the Individual Annual Reports.

Although it is not planned to produce detailed information relating to compliance in the Annual Report on 2005 data, it is possible that a similar request may be repeated at the end of this year. The changing pattern of surgical receiving often means that a proportion of patients may be admitted under one surgeon, but have most of their care delivered by another surgical team.

In order to maintain accuracy, all Consultant surgeons should now have received letters from SASM detailing cases from 2005 where patients have been attributed to them, deaths where completed forms have not yet been received or that no deaths have been attributed to them. As members of the Management

Committee will shortly be starting to write the Annual Report based on 2005 data, the audit would be grateful for your help in confirming the cases under your care and returning the outstanding forms from 2005 as soon as possible.

NEWSLETTER FEEDBACK

This is the 6th edition of the SASM newsletter which started in November 2004. The intention was to provide a link between the Management Committee and the Board of SASM and the participants. We are interested in assessing whether Consultant Surgeons and Anaesthetists in Scotland find this useful and would ask you all to complete and return the accompanying assessment form.

FREQUENTLY ASKED QUESTIONS

How should I complete SASM forms?

It can be very difficult, trawling through notes, to find the information required to complete every SASM form, but one of the commonest comments by first line assessors is that there is a lack of particular information. Some individuals are sending copies of anonymised printed discharge letters, anaesthetic or recovery charts with their completed forms. These are usually legible and can be very useful in giving a comprehensive view of the case. Examples of the type of information which is missing includes the patient who suffered acute GI haemorrhage 6 days post orthopaedic surgery with no information whether they had been prescribed and given post-op NSAIDs, and the two patients who died from presumed pulmonary embolism, with no details about anti DVT prophylaxis. Where both the first line assessor and the co-ordinator feel there is lack of information, the case notes are called and the co-ordinator looks for the missing information before making an overall decision on the case. This takes time and by identifying both the case and the individuals involved could weaken confidentiality. This can be avoided by completing the initial proforma in as much relevant detail as possible.

CORESS - Confidential Reporting System in Surgery

A report by Alastair Thompson, Deputy Chairman SASM and SASM representative on CORESS

The Confidential Reporting System in Surgery (CORESS) established by the Association of Surgeons of Great Britain and Ireland is up and running and is hosted on (www.asgbi.org.uk). Based on (and similar to) aircraft, maritime and rail industry incident reporting systems, the purpose of CORESS is, exclusively, to share lessons learnt from unexpected or adverse incidents in surgical practice. CORESS is a complementary activity to the Scottish Audit of Surgical Mortality (SASM). While SASM is an educational process which reviews patients who die under surgical and anaesthetic care, CORESS is a service provided by surgeons for surgeons throughout Great Britain and Ireland and is concerned with any safety related issue from which lessons can be learned. Any surgeon or surgical trainee, irrespective of specialty, can submit reports, in confidence, to CORESS and useful lessons may often be learned from incidents which do not result in adverse consequences and may only be known to the reporter. Confidentiality is fundamental to CORESS and the operating framework has been designed on similar lines to the very successful CHIRP aviation system.

The simple Reporting Form is available on the website and asks for some basic contact details, a description of the incident and the main causative factors. The report can be submitted by post or via the web using secure systems and will

be acknowledged upon receipt after which it is anonymised. Feedback is given by peer and evidence based review from the CORESS organisation back to the individual. The original report is then returned to the reporter and the anonymised version added to a database on a secure stand alone computer. Exemplar vignettes from incidents reported to CORESS have already been fed back to the wider surgical community by the Association of Surgeons Newsletter and are shortly to appear in the Annals of the Royal College of Surgeons of England.

The CORESS programme is primarily an educational initiative. It provides surgeons with the opportunity to pass on lessons learned from errors inseparable from active practice. If successful, the anonymised data may be of value in indicating more general areas of concern and will indicate that the surgical community is not afraid of reporting error in the interest of patient safety if the prevailing culture and conditions of the reporting system are appropriate. Participation in CORESS and SASM by the surgical community in Scotland will provide further reassurance to patients in this respect.

CORESS Feedback reports which deal with surgical problems as diverse as wrong identification to dividing the ureter are available for downloading on www.coress.org.uk