



Changes at the helm



Sir Graham Teasdale is shortly to relinquish his position as President of the Royal College of Physicians

and Surgeons of Glasgow and in doing so will also give up his position as Chairman of the Board of SASM. The three years of his tenure has seen significant developments at SASM with introduction of the Freedom of Information Act (Scotland) leading to uncertainty and anxiety within the audit. Under Sir Graham's leadership, we have resolved many of these issues. Other significant developments which have

taken place include the production of Individual Annual Reports, discussions about governance issues and the physical move from regional offices in Dundee and Glasgow to new office space at the Cirrus building beside Glasgow airport with other parts of NHS National Services Scotland. The Audit wishes to thank Sir Graham for his guidance during challenging times and wish him well in his new post as Chairman of NHS Quality Improvement Scotland.

The new Chairman of the Board of SASM will be John Orr, who was elected as President of the Royal College of Surgeons



of Edinburgh in June and is taking up office in November. John Orr is a paediatric surgeon, specialising in urology at the Royal Hospital for Sick Children in Edinburgh. He graduated from St Andrews University and during his training, worked in Dundee, Aberdeen, Edinburgh and London. John has had extensive experience of medical management, has been heavily involved in healthcare governance and surgical training, currently chairing SIBSATS, the Board for recognition of Basic Surgical Training Posts in Scotland. The Audit welcomes his appointment and look forward to using his considerable expertise to meet developments in the future.

The Case of the Missing Consultant Anaesthetists

When writing the annual report over the years, it has been noticed that there are a number of surgical deaths where an operation has been carried out, but no anaesthetic proforma is returned, or that an anaesthetic form is returned without identifying a responsible consultant. With the provision of Individual Annual Reports to Consultant Anaesthetists, some hospitals are seeing a significant shortfall in feedback, as there are deaths within their department but no identified Consultant Anaesthetist.

Surgeons are easily identified as patients included in the audit are defined as having died under a surgeons care.

All patients should have to have a responsible consultant anaesthetist. This is defined in the Royal College of Anaesthetists document CCT in Anaesthesia I, where it is

stated, "Every patient undergoing anaesthesiais cared for under the direction of an appropriate named consultant."(1) It is also Standard 1.3 in the Clinical Standard "Anaesthesia – Care before, During and After Anaesthesia" issued by NHS Quality Improvement Scotland in 2003 that "all services provided in the NHS are under the supervision of a consultant" and that "there is an explicit mechanism to identify ...the supervising consultant."(2)

There may be some difficulties in identifying a single supervising consultant with patients who die after undergoing several surgical procedures, and in some instances an unexpected death may occur following an anaesthetic carried out by a senior trainee or non-consultant career grade anaesthetist without notifying the consultant but it is important that these cases are noted

and that anaesthetists are seen to take the same responsibilities as their surgical colleagues. The Management Committee are writing to all anaesthetic departments giving the numbers of patients in 2004 and 2005 for whom no form was received or for whom a form was received but no consultant anaesthetist identified.

1. Royal College of Anaesthetists The CCT in Anaesthesia I: General Principles A manual for trainees and trainers (Interim Edition) www.rcoa.ac.uk/docs/CCTpti.pdf
2. NHS Quality Improvement Scotland, Clinical Standards, Anaesthesia – Care Before, During and After Anaesthesia. July 2003 www.nhshealthquality.org/nhsqi

Changes in Coding - An Analysis of 10 years Adverse Events

Since the inception of SASM in 1993 the circumstances surrounding the death of surgical patients in Scotland have been subject to peer review. When the reviewer identifies an "area of concern or for consideration" in the management of the patient, it is given a coded description. These "adverse events" are taken from a structured list of codes. The coding structure, or taxonomy, is currently under review as it is in need of rationalisation. As part of this an analysis of frequency of use of the codes over the last 10 years has been performed, and some of the results are presented here.

The current coding system contains 1388 codes in total, each giving a description of the adverse event. Nearly half, 626 (45%) have never been used, as there is considerable repetition and redundancy. The remaining 762 have been used on a total of 11,734 occasions. Over a 10 year period SASM has reported on 40,817 patients of whom 6,981 (17%) have had one or more adverse event codes applied to them. In each case the adverse events are further categorised in to; (1) those that made no difference to patient outcome; (2) those having contributed to the eventual outcome and (3), those which caused the death of a patient

who would otherwise have been expected to survive. These are now fed back to clinicians.

The pattern of use is skewed, with just 30 codes accounting for 50% of all codes applied. These are the subject of more detailed analysis shown below. There is then a 'long tail' of infrequently used codes. Some of these reflect rare events; others are actually variations of the more frequently used codes.

	No. codes in category	No. used 1996-2005	%
Delays	5	1567	27
Quality of care	9	1390	24
Lack of senior staff involvement	4	713	12
Surgical decision making	2	631	11
Diagnostic problems	3	519	9
Assessment problems	2	383	6
Communication problems	2	338	6
Anastomotic leaks	1	107	2
Misc.	2	178	3

The 30 frequently used codes have been grouped for ease of analysis into nine adverse event categories.

"Delays" are the largest group. The commonest code overall is delay to surgery, with others such as delay in transfer or delay in recognising complications commonplace. "Quality of care issues" is composed of a variety of codes such as inadequate resuscitation, failings in peri-operative care, lack of critical care facilities, and post operative care problems. "Lack of senior staff involvement" refers to junior surgeons and anaesthetists working unsupervised, who attract criticism from the reviewers. This practice has changed in recent years, with much greater consultant involvement now than 10 years ago. "Surgical decision making" reflects criticisms such as that the operation should not have been done at all or was not of the correct type. "Diagnostic problems" refers to missing the diagnosis or making the wrong one. "Anastomotic leaks" are the commonest specific surgical complication cited, they also appear in lesser used codes.

Most of the adverse events identified in these codes have been highlighted by SASM in the past but it is useful to see the relative frequencies and their occurrence. The taxonomy system is currently being overhauled. The aim is to produce a simpler structure which will more easily capture and describe failings in care of surgical patients who die.

Assessors meeting

Another successful Assessors meeting was held in the Royal College of Physicians and Surgeons in Glasgow on 13th September 2006. Once again, it was organised by Charles Wallis, Anaesthetic co-ordinator for East of Scotland. Items discussed included the future of SASM by Nick Pace who raised a number of the contentious issues confronting the Management Committee at the present time. Presentations on Individual Annual reports were made by Gillian McPhillips and Lynsey Kerr, the statisticians who compile your reports. There was an opportunity to discuss assessments using anonymised cases, which was highly rated by participants and Mark Lansdown from NCEPOD reported on the experiences in England and Wales.

Feedback indicated that participants felt that the meeting had educational merit and valued the opportunity to attend the meeting.

The afternoon closed with a lively discussion about how SASM should deal with the problem of clinical governance, promoted by the draft discussion document on this topic on the SASM website at www.sasm.org.uk about the action to be taken when serious concerns become apparent during the audit process. Doing nothing or launching a SASM sponsored enquiry had low response rates of 2 each but the remainder of the respondents were almost evenly split between communication with the Medical or Clinical Director or, (preferred by a small majority) the consultant identified as responsible for the patient. The communication would simply request confirmation

that the patient's care and outcome had been considered within local review and clinical governance processes. Comments from this meeting and also the Management Committee, the Liaison Committee, the Scottish Medical Directors Group and other individuals and groups were taken into account by the Board of SASM when the topic was debated at its November meeting.

The next Assessors Meeting is likely to be held in May 2007 as the Management Committee is in the process of overhauling the coding system presently used and would plan to introduce these changes in the 2007 cases. Individuals who are interested in becoming assessors are encouraged to contact SASM by telephone or e-mail or to contact their Specialty Coordinator to discuss the commitment.