

Board of Directors Meeting: Thursday 3 September 2009

BD2009.79

Subject	Group on the Management of Surgical Risk			
Purpose of paper	To report to the Board of Directors on the establishment of the Group on the Management of Surgical Risk, its membership, and its work plan for the coming months.			
Board Lead(s)	Mrs Elaine Strachan-Hall, Director of Nursing and Clinical Leadership			
Background papers (if any)	BD2009 46 Briefing on action taken to improve patient safety (May 2009)			
Action/decision required	To note the progress made To note that a further report will be made in November, following the training day to be held on 20 October 2009			
Key purpose	Strategy	<u>Assurance</u>	Policy	Performance
Strategic Goals	All and specifically SG1: To be hospitals of choice			
Strategic Objectives	SO6: To provide demonstrably excellent clinical outcomes and indicators of patient safety SO8: To improve the overall patient experience by offering excellent customer care. SO9: To maximise the Trust's contribution to the health and wellbeing of the local community.			
Links to Board Assurance Framework/ Trust Risk Register/Annual Health Check element(s)/CQC Registration	The risks to the above objectives are monitored through the Board Assurance Framework and through the Trust Risk Register Several core standards apply, including: C1a: Patient safety and incidents; C5b: Supervision and leadership of clinical treatment; C5d: Clinical audit and clinical reviews; and C7a and 7c: Governance and Risk			
Also considered by	Not applicable			
Resource and financial impact	The final recommendations of the Group may result in the requirement for resources. A full case will be			

	made at that point
Consideration of legal/equality/diversity/engagement/risk issues	Considered as part of the overall approach
Acronyms and abbreviations used	CQC: Care Quality Commission SpR: Specialist Registrar SUI: Serious Untoward Incident
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### Update on the management of surgical risk

#### Introduction

1. The Board of Directors agreed the establishment of the Group to consider the management of surgical risk at its meeting in May 2009. A short update report was provided on July 2009.
2. This report provides a full progress report on the membership of the group and the work planned for the coming months. The group expects to be able to report to the Board with its findings and recommendations at the end of the year.

#### Membership

3. The group now has the following membership:
  - 3.1. Mr Peter Stevenson – chair
  - 3.2. Mr Tony Giddings – nomination from the Royal College of Surgeons and chairman of the Alliance for the Safety of Patients
  - 3.3. Ms Jane Reid – Theatre nurse and past president of the Association for Perioperative Practice
  - 3.4. Mr Michael Hocken – member of the Trust’s Patient Panel
  - 3.5. Mr John Reynard – consultant Urological Surgeon
  - 3.6. Dr Jon Warwick, Consultant Anaesthetist and Dr Suzy Lomax, SpR in Anaesthetics
  - 3.7. Mrs Elaine Strachan–Hall, Director of Nursing and Clinical Leadership
  - 3.8. Mrs Megan Turmezei, Associate Director of Governance
4. Mrs Clare Bowen has also been invited to take part in the work of the group and the details are now being worked out on how best she can contribute.
5. In addition, the resources of, for example, the Trust’s Safety, Quality and Risk Team and the Technologies Advisory Group, will be drawn on to support the group’s work.

#### Programme of work

6. The scoping meeting of the group took place on 20 July 2009, and the terms of reference and proposals were reviewed. Although not all members could be present, good progress was made in deciding the key areas of focus. Dates were fixed for the next four months’ meetings.
7. In introducing the meeting, Mrs Strachan–Hall hoped that the working group would draw on experiences and best practice from elsewhere to lead to the Trust becoming an exemplar in patient safety in all areas including surgery. The group agreed that this was an appropriate objective and one that would include multi-disciplinary working. In addition, the group would liaise closely with the Technologies Advisory Group, chaired by Professor Hamdy, and integrate any recommendations

arising from its work in the assessment of new technologies, techniques and procedures into practice within the Trust. It was agreed that it would not be appropriate to duplicate the work of the well-established group.

8. Organisational learning from serious untoward incidents (SUIs) (and from best practice elsewhere) and human factors were recognised as a crucial elements in changing the approach and response to the management of risk. The Bowen SUI (which had led to the establishment of the group) was regarded as the sentinel event with key lessons to be learned.
9. A number of group members had a specific interest in training and in human factors and it became clear that organisational learning, training and cultural change would be key. Experience had shown that failures, mistakes, near misses and disasters tended to occur from similar causes including identification errors, failure to check, communication errors and failure to learn. The advances within the aviation industry and, for example, the petrochemical industry, were built on key elements as follows:
  - 9.1. the process of investigation – with often external investigators;
  - 9.2. the development of standard operating procedures to avoid recurrences of errors and failings supported by appropriate communication tools;
  - 9.3. continued audit of the standard procedures;
  - 9.4. a supportive training process covering not only the procedures and process but also the importance of continued audit.
10. The Group agreed that it was likely that a recommendation would be made in relation to the need for training within the Trust. It was agreed that a full day meeting would be set up to test a potential multidisciplinary training programme for clinical staff building on the experience of Mr Stevenson, Mr Reynard and others. The meeting has been scheduled for 19 October and plans are underway for its design. Key ‘disciples’ from a number of clinical specialities have been identified to test the programme and the timetable will allow for critical evaluation and assessment .
11. In addition, it became clear that there are already a number of pieces of work being done within the Trust that will contribute to improvements in patient safety. These include the introduction of the Surgical Check list now being rolled out across the Trust. A ‘portfolio’ of initiatives is being compiled for review by the Group and for external members to bring other initiatives to the attention of the Group.