SURGICAL QUALITY ASSURANCE MEETINGS
Developing the Surgical Morbidity & Mortality Conference

April 2015
ISSUES IN PROFESSIONAL PRACTICE
SURGICAL QUALITY ASSURANCE MEETINGS
Developing the Surgical Morbidity & Mortality Conference

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**SERIES FOREWORD**

*Issues in Professional Practice* (IIPP) is an occasional series of booklets published by the Association of Surgeons of Great Britain and Ireland to offer guidance on a wide range of areas which impact on the daily professional lives of surgeons. Some topics focus on clinical issues, some cover management and service delivery, whilst others feature broader aspects of surgical working life such as education, leadership and the law.

This latest IIPP booklet, on *Surgical Quality Assurance Meetings: Developing the Surgical Morbidity & Mortality Conference*, addresses a key theme, which traditionally has formed a central component of quality assurance within surgical departments. There is increasing NHS and specialty emphasis on aspects of surgical safety, quality assurance and improvement, and learning from adverse events and near-misses. Development of a formal framework in which surgical departments can actively demonstrate their participation in quality assurance, to interested bodies, and can influence standards of care for surgical patients, has attained increasing importance.

This joint publication with the Confidential Reporting System for Surgery (*CORESS*) offers a template for refinement of the traditional Morbidity & Mortality Meeting into a more encompassing forum, the Surgical Quality Assurance Meeting, through which surgical departments in NHS Trusts can embrace and develop aspects of safety and quality of care for all surgical patients. The template has pan-specialty relevance and can be employed in all surgical arenas.

The Association intends that this publication, and others in the series (all of which are accessible at: [www.asgbi.org.uk/publications](http://www.asgbi.org.uk/publications)), will provide concise advice and guidance on major current issues, and prove to be a helpful and accessible resource to support your professional practice. We welcome feedback on this and other booklets in the *Issues in Professional Practice* series, and proposals and contributions for future issues in the series.

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INTRODUCTION

From the moment they set foot in medical school, it is impressed upon doctors that they bear an onerous duty of care for their patients. The authorities and occasional inquiries into medical mishaps regularly reinforce this message. Despite being in the best position to direct the business of delivering specialist surgical care, clinical teams often find themselves confounded by factors which lie outside their control. The Inquiry into the failures at the Mid Staffordshire NHS Trust demonstrated how the lack of an effective mechanism through which the clinical voice can be heard inevitably results in the active disengagement of those involved.

I am delighted to see that the profession, as represented by the Association of Surgeons and CORESS, is taking the lead in recommending a pragmatic solution to a continuing risk. The authors of this joint ‘Issues in Professional Practice’ booklet point out that many surgical departments are already developing their meetings along lines similar to those suggested here. The recommendations in this guide require a modest investment to achieve their full potential. It is to be hoped that hospital trusts and their managers will see the advantages of a model that devolves responsibility for quality assurance and innovation closer to the point at which surgical care is delivered.

The Lord Ribeiro, CBE
Chairman
CORESS Board of Trustees

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EXECUTIVE SUMMARY

1. The Inquiry into the problems at the Mid-Staffordshire Hospital demonstrated how the disengagement of clinicians from Clinical Governance and Quality of Care can lead to a catastrophic drop in standards.

2. The Association of Surgeons of Great Britain and Ireland (ASGBI) works with the Surgical Royal Colleges to advise on standards and is concerned to see that long-term solutions to these problems are developed.

3. The Confidential Reporting System in Surgery (CORESS), as a registered charity, works independently with a number of medical specialties to collect cases of surgical adverse events and near misses, analyse causes, and publish regular feedback on lessons learned for the wider surgical community.

4. The two organisations support the case for a better understanding and ownership of issues of Quality and Safety by clinical teams. The traditional Departmental Morbidity & Mortality Meeting (M&M) is ideally placed to facilitate any changes.

5. This Guide explains how Surgical Departments and parent Trust hospitals can expand the purposes of the traditional surgical M&M Meeting, to provide a more systematic, timely and comprehensive evaluation of the quality of care being delivered.

6. This Guide makes the following recommendations:
   a. That the Meetings are a fixed commitment and include an expanded range of Quality Indicators relevant to the clinical care, which members deliver.
   b. That a Chair is appointed for a fixed period of one to three years.
   c. That the role of the Chair includes:
      i. Oversight of preparations.
      ii. Leadership of the Meetings.
      iii. Framing appropriate outcomes and learning points and ensuring dissemination.
   d. That an Administrative Assistant is appointed to collect data and support the Chair and the Meetings.
   e. That a comprehensive range of Quality Indicators, in addition to mortality and morbidity, are considered during each Meeting cycle. These include incidents, near misses, low harm events, ‘Never Events’, patient feedback, and clinical audit figures for the surgical teams within the Department, etc.
f. Case presentations should conform to a standard framework; ‘SBAR’ is recommended.

g. Learning outcomes and recommendations from Meetings should be used for Quality Improvement within the Department and, where appropriate, disseminated via Trust Patient Safety Committees within the Trust.

h. Job descriptions include time allocated for the duties of Chair, Administrative Assistant and those required to attend the meetings.

i. That the title of Meetings should reflect the enhanced role of the process. ‘Surgical Quality Assurance (SQA) Meetings’ is suggested.

7. This Guide offers practical advice on how to approach the transition from M&M to SQA Meetings, and also suggests how practical problems during implementation may be addressed.

8. It is hoped that the adoption of these recommendations will help to provide significant improvements in surgical care. The development of an effective Departmental Quality Assurance and Improvement platform is seen as an essential prerequisite for monitoring standards, disseminating learning from experience, and for bringing about evidence-based change where necessary.
CHAPTER 1: 
WHY SURGICAL QUALITY ASSURANCE MEETINGS, AND WHY THIS GUIDE?

“The common sense notion that every hospital should follow every patient it treats, long enough to determine whether or not the treatment has been successful, and then to inquire, ‘If not, why not?’ with a view to preventing similar failures in the future.”

End Results Idea [1.1]
Ernest Amory Codman (1869-1940)

Ernest Codman’s ‘End Result Idea’ was one of the first calls for systematic Clinical Audit. It contributed to making him deeply unpopular with colleagues in his hometown of Boston, Massachusetts at the time, but his demand for continuous evaluation of clinical quality is as valid today as it was then.

The findings of the Mid Staffordshire NHS Foundation Trust Public Inquiry [1.2] have prompted all Trusts to review their systems of clinical governance. At the heart of good clinical governance lies the requirement for satisfactory quality assurance and improvement through learning. This Guide makes the case for evolving the traditional Morbidity & Mortality (M&M) Conference into an effective quality assurance forum - the Surgical Quality Assurance (SQA) Meeting - and shows how it can be achieved.

The differences between the traditional M&M Meeting and an SQA Meeting are significant [1.3]. Whereas the former confines itself to learning from an examination of hospital deaths and significant morbidities, the SQA Meeting is a forum which brings together additional important indicators of quality, providing a more comprehensive and accurate overview of the care delivered.

The SQA Meeting brings together those who deliver the core business of specialist surgical care. Delivery of clinical care is a complex process which demands exercise of judgement. The assessment of those judgments requires peer review. The SQA Meeting - or its equivalent - provides a forum in which that can take place.

The General Medical Council, in its guidance Good Medical Practice, which is issued to all doctors [1.4], states:

“22. You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:

a) taking part in regular reviews and audits of your own work and that of your team, responding constructively to the outcomes, taking steps to address any problems and carrying out further training where necessary
b) regularly reflecting on your standards of practice and the care you provide

c) reviewing patient feedback where it is available.

23. To help keep patients safe you must:
   a) contribute to confidential inquiries
   b) contribute to adverse event recognition
   c) report adverse incidents involving medical devices that put or have the potential to put the safety of a patient, or another person, at risk
   d) report suspected adverse drug reactions
   e) respond to requests from organisations monitoring public health. When providing information for these purposes you should still respect patients’ confidentiality.”

Francis [11,51] emphasised that:

“The creation of a caring culture would be greatly assisted if all those involved in the provision of healthcare are prepared to learn lessons from others and to offer up their own practices for peer review. Whilst peer review will have a specific relevance in cases of practitioners where there may be concerns about substandard performance, it has a far more fundamental role in changing behaviour to ensure a consistent and caring culture throughout the healthcare services. Peer review therefore needs to be a key part of the delivery and monitoring of any service or activity, and those involved need to demonstrate that this element of monitoring and learning is integral to the process of compliance with fundamental standards and of improvement.”

Surgeons, and their teams, understand the business of delivering surgical care and are well placed to monitor standards, feed back into the wider system, and provide at least some of the solutions that can improve standards and solve problems. It is hoped that these guidelines will also help surgical teams to achieve the clinical leadership that is vital if standards are to be maintained and improved.

The forum outlined in these pages provides a mechanism for a more joined-up approach to quality than the somewhat fragmented systems that have evolved in many Trusts. Crucially, it is conducted close to the point of delivery, where problems can be identified at an early stage and local solutions devised. Outputs of meetings are fed through into Trust-wide systems for Quality...
Improvement. Conversely, the same forum provides a conduit for information from Trust systems to be received and processed.

There is an additional advantage to this approach. The Mid Staffs Inquiry demonstrated how clinical disengagement can present a real threat to such agendas. Surgeons and their teams working in the NHS, have a duty of care and advocacy for their patients. This has to be balanced against the responsibilities to employers. Francis [1.6] stated:

“The system is designed for directors to lead and manage the provision of services within its allocated budget but in accordance with required standards, and for professional staff, informed by their ethical standards and commitment, to serve and protect their patients.”

The Code of Conduct published by the Nursing and Midwifery Council [1.7], also makes clear that nurses are personally responsible for the standards of care that they deliver, and that they must engage in a process of continued learning and development.

One of the root causes of the poor care being delivered in the Mid Staffordshire NHS Trust was disempowerment of clinical teams [1.8]:

“…..there was an atmosphere of fear of adverse repercussions; a high priority was placed on the achievement of targets; the consultant body largely dissociated itself from management; there was low morale amongst staff; there was a lack of openness and an acceptance of poor standards…..”

There is also an issue regarding nomenclature. The ‘M&M’ title and construct is familiar to all who are involved. Some Trusts and departments may already be developing their meetings along the lines being suggested here. M&M meetings already occupy the ideal ‘space’ where issues concerning the quality of practice are best discussed, and from which ideas for improvement can flow. They are conducted close to the location of delivery of care and they are ‘owned’ by those who are in the best position to introduce change. ASGBI and CORESS feel that, regardless of how the format may change, it is of paramount importance that this remains the case.

Much of the relevant literature continues to refer to M&M Meetings. Perhaps the term M&M will be retained in some Trusts. In others, it will replaced by ‘The (Surgical) Quality Assurance Forum’; ‘Surgical Clinical Governance Meeting’ or similar. Some may find it an advantage to adopt a different nomenclature, but, whatever the title, the authors hope that the practical suggestions in this guide will prove helpful.
SUMMARY

A strong culture of patient safety, deeply embedded at all levels within a Hospital Trust:

• Is essential for the safe delivery of high quality surgical services.
• Fosters a climate conducive to personal and system learning.
• Is essential to minimise the risks inherent in the delivery of interventions.

Developing such a culture is not always easy and requires positive steps. Specifically, it requires:

• Trust on the part of those who deliver interventional services that honest reporting will be used positively and not as a means to apportion blame.
• Facilitation by those who hold executive authority.
• Recognition of the boundaries between specialist professional and management responsibilities.

Supported in this way, the effective Surgical Quality Assurance (SQA) Meeting will:

• Help to develop an environment in which a safe, productive culture can flourish.
• Provide an effective Surgical Quality Assurance mechanism for Hospital Trusts.
• Help Departments identify and implement improvements to their clinical services.
• Inform Trust-wide Quality Assurance and Improvement Programmes.

In terms of attitudes to Patient Safety, the culture at operational level is influenced by the responses of the organisation to the reporting of instances of harm and system failure. This experience has a direct impact on behaviours. For example, a negative or apathetic response to the reporting of a system failure decreases the likelihood of candour and discourages ownership of error. A positive response encourages staff to voice concerns and express an honest opinion.
Reason [2.1] suggests that an effective safety culture includes several elements:

- An informed culture.
- A reporting culture.
- A learning culture.
- A just culture.
- A flexible culture.

These elements support the development of practices that are designed to reduce the frequency of error through personal learning and system development.

The informed culture
The organisation that has developed an informed culture, collects, keeps under review, and analyses relevant data. It actively disseminates safety information. An effective Surgical Quality Assurance Meeting will do just this.

It is recognised in Human Factors training and system design that error is inseparable from the human condition. There are few more complex, highly pressured, high-stake environments than those that exist in Medicine. Vincent [2.2] suggests that:

“When error is understood to be common, even affecting the very best practitioners... largely precipitated by events outside of our control and often outside our conscious control, blame is more than just morally wrong; it is just irrelevant to the quest for safety.”

Viewed in this light, error can be seen to be inevitable, but its translation into harm is not. In the majority of cases, it is preventable. For this reason, the recognition of precursors in the form of low or no-harm events is essential.

The reporting culture
The organisation which has a reporting culture demonstrates, through its actions and behaviours, that it values reports of error, safety concerns and suggestions for improvement. This is not just a matter of putting up signs and saying ‘thank you’ to staff that send in a report. It respects confidentiality, seeks not to apportion blame, is inclusive and puts in place pathways that facilitate reporting. Above all, it is seen to take action when staff report a concern about safety.

In a healthy reporting culture, staff recognise precursor events (unintentional errors, near misses and low or no-harm incidents) and take action. Often, the only person who is witness to such an incident is the person directly involved.
Major accidents are usually not the result of recklessness, carelessness or inexperience, and it is the system or common practice that may be at fault. Unless the culture is right and staff regard it as their duty to report, and feel that they can do so honestly without fear of retribution, vital opportunities to avoid disaster will be lost.

A well-conducted Surgical Quality Assurance Meeting is an invaluable opportunity for senior staff to demonstrate, to their trainees and others, their commitment to an open ‘reporting’ culture.

**The learning culture**
A learning culture implies that an organisation is able to learn from its mistakes and make appropriate changes. Such organisations demonstrate the will and competence to draw accurate conclusions from their safety information systems then use them to take appropriate, and timely, action. This may involve difficult decisions. For example, an organisation where safety is taken seriously will recognise when it needs to reduce output and activity in order to manage risk satisfactorily [2,3].

The effective Quality Assurance Meeting ensures that concerns and suggestions for improvement are received close in time and place to the point where care is delivered. Circumstances at the time can be discussed whilst memories are fresh and the staff involved are still available. Accurate information is to hand, and this makes it more likely that fact, rather than recollection, is interrogated [2,4]. Timely action taken on the basis of such locally generated and processed information offsets the tendency by staff to disengage when untoward events are managed centrally.

**The just culture**
A completely no-blame culture can lead to a loss of accountability and a tolerance of inappropriate actions and behaviours. This is clearly nonsense and highly undesirable. A ‘just’ culture recognises this, and is able to balance the approach taken in dealing with unintentional errors or mishaps as opposed to those that are brought about by neglect or recklessness. When achieved, it makes clear that the accountability for personal actions remains, but will not be used inappropriately to threaten or inhibit [2-1]. This is a challenge for any organisation; it takes time to achieve, and is easily damaged by poor leadership or single acts of heavy handedness. The Surgical Quality Assurance Meeting, as a peer-reviewed, non-threatening exercise, is in a unique position to achieve this balance, particularly when dealing with the complexities of clinical practice.

**The flexible culture**
This is a culture where the organisation, and the people in it, is capable of adapting to the changing needs of those it seeks to serve.
Moreover, it does so effectively and in a timely manner. It addresses the need for resilience, essential for success in any organisation. As applied to Surgical Quality Assurance Meetings, this means that case and data review must be accompanied by action. Without action the value of such exercises are much reduced.

The flexible culture encourages an approach that:

- Anticipates problems.
- Encourages good behaviours.
- Supports a strong team culture.
- Develops situational awareness.

Encourages adaptation through improvisation as well as standardisation and automation, thereby making it easier to do the right thing and harder to do the wrong thing.
CHAPTER 3: WHAT AN EFFECTIVE SURGICAL QUALITY ASSURANCE MEETING MIGHT LOOK LIKE

SUMMARY

This short narrative provides a snapshot of a Surgical Quality Assurance Meeting which has been developed along the lines suggested in this guide.

It is clear that there will be considerable variation between departments and specialties, but this section describes how one department might conduct a typical meeting.

This Surgical Quality Assurance Meeting is held in a quiet, well-equipped and well-ventilated room. It is the custom in this department to hold these meetings weekly, during a lunchtime, when availability is good. Other departments meet first thing in the morning, before clinics and lists commence. Some rotate meetings through the days of the week to facilitate attendance.

This meeting is scheduled to last no more than 45 to 50 minutes, and is timetabled so that the clinical commitments of the department and those attending are minimal. It has been well advertised and, in any case, is a regular fixture, with fixed dates advertised in advance, for the coming year.

Participants include a cross-section of senior and junior medical staff, some nurses, a Data Assistant and a member of the Trust Patient Safety Committee. An attendance register is circulated during the proceedings.

The Data Assistant has circulated an agenda listing the cases to be discussed, and has also drawn down the overall activity figures from the data bank, which he maintains for the Department. He has also provided other relevant information for the Chair and those who are due to present.

The Chair opens the meeting on time, and notes apologies for absence. She requests that pagers and telephones either be switched off or placed in silent mode. She reminds the meeting that, while outcomes will be incorporated into the minutes, what is said during the meeting does not leave the room. The Minutes of the previous meeting have been circulated, and the Chair asks for comments and amendments to matters of fact etc., before signing them as an accurate record of the previous meeting. There are notifications from the Trust Patient Safety Committee to which she draws members’ attention. She also reports that, as a result of a
department project on pressure ulcers, the nursing staff have now obtained some new equipment and are also using ‘heel mirrors’ to monitor the circulation routinely on all patients.

The Data Assistant then displays the departmental activity figures for the previous period. All deaths and complications are tagged, together with one or two denominator statistics. There follows a few brief comments/questions from the Chair and audience before this section is drawn to a close and proceedings move on to the formal presentations.

Presentations commence. The Chair has selected beforehand the cases to be presented for detailed discussion. The firms involved have been notified. Trainees present most cases, but Consultants present others. PowerPoint \(^\text{®}\) presentations are employed, and each case follows a standard format that has been adopted by the meeting - in this case, it is the SBAR \(^{[3,4]}\) framework (ie. Situation, Background, Assessment and Recommendations).

Case presentations include all relevant investigations and a display of the radiological and clinical imaging as appropriate. Presentations are succinct. In one instance, the Chair intervenes to encourage progress. Only initials and hospital number identify patients. Presentations include a brief review of the literature and the clinical team’s analysis of what was done well and what could have been done better. There follows a brief, focused discussion and agreement/dissent with the analysis. Conclusions are agreed upon and include one or two recommendations, before the Chair sums up and moves on to the next case. The Data Assistant takes notes, from which the Minutes will be written-up and circulated.

There were no particular problems identified in the majority of cases, but the second of two recent cases of \textit{C. difficile}, both of which were associated with lengthy periods on antibiotics, was presented. This will cause ripples outside of the department, as these will affect the Trust performance indicators. The presenting SpR is tasked with carrying out an urgent audit of departmental antibiotic usage and conformity with Departmental/Trust/Microbiology protocols. This is to be presented in one month’s time and necessitates working with the microbiologists and pharmacy.

Discussions are conducted in a frank and courteous manner without ducking some uncomfortable issues and criticisms. The Chair encourages active participation from a wide range of the audience and stops one or two attempts at ‘grandstanding’ by one of the more senior members in the audience. Contributions are focused, constructive and courteous. It is noticeable that the discussions follow a predetermined framework and that they focus on learning points relating to best practice and system problems.
It emerges from another case discussion that there is a problem with communication between clinical teams and nursing staff. One of the Consultants undertakes to produce a proposal for the next Departmental Meeting to address what is clearly a chronic problem with timetabling, and an SpR is instructed to submit a report to CORESS.

The Chair sums up the learning, and notes that one case of mortality, where a repetitive system-based problem has made a significant contribution, is to be referred to the Patient Safety Committee, and another is to be reported to CORESS by the SpR. She concludes with a reminder of the time and place of the next meeting, at which the quarterly Clinical Audit figures for the Senior Staff will be presented. She thanks all who attended and the meeting concludes on time and with one case carried over for the next meeting.

All papers related to patient details are collected for confidential waste disposal.
CHAPTER 4: THE PROFILE AND ROLE OF THE SQA CHAIR

SUMMARY

The role of the Chair of the Surgical Quality Assurance (SQA) Meeting is critical for success. An effective Chair will ensure that:

• An appropriate environment for discussion is developed.
• Learning points from clinical outcomes, both good and poor, are developed and promulgated.
• There is objective analysis of clinical outcomes.
• Recommendations for improvement are drawn up, recorded and channelled to appropriate quarters.
• Actions recommended are monitored for resolution.
• Attendees actively participate.

Most importantly, the Chair, working with others, has the authority to influence Trust Quality Assurance, Patient Safety and Quality Improvement agendas.

• It is recommended that the role of the Chair should be:
• Underpinned by a job description.
• A fixed-term appointment for a period of a minimum of one to three years.
• Provided with designated and resourced administrative support.
• Incorporated within the Clinical Governance Structure of the Trust.

In the interests of clarity, the main tasks of the Chair are laid out in the form of a job description. A sample job description is included in this guide as Appendix 1. This chapter examines the requirements of the role.

The Tasks of the Chair include:

• Ensuring adequate preparation for the meeting.
• Moderation during the meeting.
• Drawing out educational/learning content.
• Picking up on serious quality and performance issues.
• Dissemination of outcomes of the meeting.
• Ensuring that recommendations are followed up.
THE PROFILE AND SELECTION OF THE SQA CHAIR
Given the importance of the position, selection of an appropriate colleague is essential. He/she should be a respected physician (surgeon) with strong meeting management and educational skills \[^{4.1}\]. Much will depend on the membership and specialty orientation of the meeting. The Chair need not be an expert in patient safety, but should be up-to-date with safety initiatives and should be a team player who is clearly motivated to drive forward the departmental quality assurance and improvement agenda, including participation in Trust-wide initiatives.

Efficient and objective analysis of cases can be assisted if the Chair has an understanding of Root Cause Analysis (RCA) \[^{4.2}\] methodology and Human Factors (HF) \[^{4.3}\] theory and practice. This could be included in a personal development programme.

FIXED TERM OR ROTATING APPOINTMENTS
Surgical Departments vary in their approach to the role. In some, it is the tradition that the post of Chair rotates among the consultants \[^{4.4}\]. There are potential problems with this, namely:

- The quality of moderation and, therefore, the meetings as a whole may be inconsistent.
- It makes it less likely that the role will be developed and become fully effective.
- As far as project development is concerned, a single leader, supported by others, is more likely to succeed than a number of individuals – as, for example, in acquiring the necessary resources from Trust budgets.
- If the departmental SQA is to become a significant force in a Trust’s clinical governance framework, a single advocate mandated to work on behalf of the whole department, and completely focused on the project, is more likely to be effective than multiple leads.
- Multiple leads make systematic preparation and planning for meetings more challenging.
- By channelling its experience and findings through a single individual, a department will be better placed to participate in the Trust network of Clinical Governance and Patient Safety systems.

Set against this are the well-recognised problems that can flow from a poorly performing incumbent if an unsuitable appointment is made. This aspect may be something to include in periodic review of the meetings. It should be emphasised that, if a Chair
does not have a real enthusiasm for the role, then the meetings are likely to fall short of expectations.

There are other options. One is to appoint a colleague from another specialty. This may help develop the essential mix of impartiality and objectivity on the part of the Chair, but limited understanding of the surgical department and surgical practices is likely to be an impediment to effectiveness.

The key point is that the Trust should give proper recognition to the role. The role must have appropriate time built into the job description, if the duties are to be discharged satisfactorily.

**SUGGESTED FURTHER READING**

A free download of a guide to Chairing Skills is available at:

CHAPTER 5: ADMINISTRATIVE SUPPORT FOR THE SURGICAL QUALITY ASSURANCE MEETING

SUMMARY

The tasks of a Departmental Administrative Assistant might be part of a wider role within a department, but should include the following:

- Data collection and entry into an audit database.
- Data retrieval for meetings.
- Equipment maintenance and storage if necessary.
- Facilitation, including protocols, communications, meetings set-up and close down.
- Assisting the Chair in discharging their duties and responsibilities.
- Liaison with the Trust systems for Quality Assurance and Quality Improvement.

Aside from an effective Chair, administrative support is likely to be the most critical step for success of the programme [5, 5]. The title of the post is immaterial. Whether it goes under the title of Administration Assistant, Data Clerk, Clerical Assistant, Technical Officer, Research Assistant, Clinical Governance Assistant, etc., or whether it is full or part-time, is relatively unimportant. It may, for example, be included as part of a wider role within the Trust or Department. The point to address is that there is a clear understanding of the purposes and requirements before any appointment is made. An outline job description is included in this guide as Appendix 2.

The duties will vary somewhat according to circumstances. The needs of the meetings may be addressed in a number of ways. As a general principle, the more the requirements for meetings can be integrated into a single role, the better. Fragmentation of tasks across a number of roles is likely to lead to problems and make for poor job satisfaction.

The Assistant reports to the Chair and is accountable to the Head of the Department through him/her. Disparate lines of accountability make for muddle and confusion.

Access to reliable data is clearly essential, but experience shows that, in any new venture, it sometimes takes time and effort to
achieve the necessary standards of quality. As a general principle, it makes sense to keep the ‘ownership’ of data collection and entry as close as possible to the point of use, i.e. at departmental level, but this may conflict or duplicate Trust-wide systems already in place. However, it is generally accepted that: “The further away it is collected from the point at which it is generated, either in place or in time, the less reliable data becomes”.

The contribution which a competent and enthusiastic administrative assistant can make to the development, smooth running and quality of this type of Departmental activity, cannot be overestimated, and great care should be taken to ensure a good appointment is secured.
CHAPTER 6:
CONTENT AND PROGRAMMING OF A
SURGICAL QUALITY ASSURANCE MEETING

“To err is human. To cover up is unforgivable. To fail to learn is inexcusable.”
Sir Liam Donaldson, Chief Medical Officer, 2004 [6.1]

SUMMARY

- The Surgical Quality Assurance (SQA)/Clinical Governance Lead should determine and control the content of meetings.
- The pressures of time make ‘Lean Thinking’ essential, if the entire range of suitable material is to be considered.
- Meeting agendas should include regular reviews of clinical outcomes in addition to all deaths and significant morbidity.
- Additional elements such as SUIs, Never Events, Incident Forms and Patient Complaints contain important learning and should be incorporated into meetings, routinely.
- Pre-planned programming of meetings, such as results of a subject-specific clinical audit, may help to incorporate occasional items. Data, method of collection and presentation, should be agreed and standardised.
- This Chapter links with Chapter 7: Preparation for the SQA Meeting.

LEAN THINKING

The purpose of this section is to be clear about what is appropriate for inclusion in an M&M meeting, bearing in mind the conflicting needs of efficient use of time, set against the requirement to consider a substantial volume of material. ‘Lean Thinking’ [6.2] is a useful principle and watchword. Having stated this, it will be for the Department to decide on the data it feels will provide the necessary assurances regarding the quality of care. Where the timeframe of meetings is constrained, imparting information on a “need to know” basis considerably outweighs “nice to know”.

The prime consideration throughout is to identify valuable learning content. Conversely, where material contains little or no learning, it is important not to waste valuable time on its presentation or dissection; for example, expected and unavoidable deaths. In the interests of time, the most important cases should be prioritised.
Issues surrounding human resources, terms and conditions of employment, and industrial relations have little educational value, and the SQA Meeting is an inappropriate forum for discussion of these topics.

**A ROLLING PROGRAMME**

The content of meetings can be modified in the light of experience. It is not necessary to include all fields for each meeting. The advantage of a predetermined rolling programme is that occasional reviews, such as the cumulative experience of managing a single condition, can be fitted around the fixed standing items on the agendas. An annual evaluation of the programme will be helpful in managing this aspect (see Chapter 13).

**DATA COLLECTION**

Paramount to the success of the meeting is a robust system for data collection. Data collection and accessibility are required to be:

- Secure.
- Accurate.
- Complete.
- Fit for purpose.
- Timely.

It is likely that data relevant to meetings will reside in a number of locations. It is expected that each will be secure, and meet the requirements of the relevant Caldecott Guardian. Local systems must allow cases to be recorded into a secure location, preferably using a standardised method so as to make presentation easier. For example, those individuals responsible for collecting and presenting data could be granted access to a specific, confidential, shared drive on the hospital intranet with forms available for contemporaneous completion and presentation at the meeting; in effect, a ‘toolbox’ of helpful documents.

**CLINICAL CODING**

Accuracy and completeness of data collection and coding are prime considerations for all Hospital Trusts and their Consultant staff. If data collection and validation is already carried out at Departmental level, it will sit well with the data requirements for the SQA. At the very least, close liaison between those responsible for the collection and coding of a Department’s clinical workload and the SQA Administrative Assistant is essential and may be of mutual benefit.

Where possible, the system for data entry should be designed to help guard against accusations of record falsification, either by design or accident. For example, the collection and entry of data could form one of the duties of the Administrative Assistant or could be triangulated against clinical coding department entries.
National clinical audit systems have been developed and generally reside within the various Royal Colleges and Specialty Associations. They should be used to their full potential. Important registries such as the National Joint Registry for Orthopaedics [6.3], and the National Vascular Registry, have emerged. These are important sources of quality assurance information, and data from sources such as these should be routinely included in the rolling programme.

The data requirements for a Departmental Quality Assurance Meeting will change as time goes by. It is important to keep them under review, so that when new needs are identified, those that have become superfluous are culled.

THE REVIEW OF ACTIVITY (CONTEXTUAL INFORMATION)
It is important that the discussions surrounding specific cases are set within the context of activity overall. At the start of a meeting, it is worth presenting, in a format agreed locally, the workload during the period being considered. It is to be expected that Trust management and the local information (IT) services will work with departments to facilitate this. Routine data sets might include:

- The number of admissions and discharges.
- The operative workload, including day cases (under the headings of elective, urgent or emergency, and further subdivided into minor, intermediate and major categories).
- Cancelled activity, such as operations, OPD appointments and the reasons.
- A periodic review of clinical audit and national registry data.

MORTALITY
Cases of mortality must be displayed at quality assurance meetings and unexpected deaths discussed. It is unlikely to be practical, or useful, to present all cases in detail, but a comprehensive list with a brief written synopsis against each is helpful and provides an opportunity for questions.

The Consultant in charge of the case, and/or the Chair, should have identified the cases for detailed review beforehand. Discussions during the meeting aim to identify in each case what went well and what could have been done differently or better. Within each Trust, there may be a specific ‘Mortality Review Form’ used for the presentation of cases at Trust governance meetings. This may be useful in providing a framework that helps analysis and discussion. The ‘Situation - Background - Assessment - Recommendations’ (SBAR) framework has been found to be useful [6.4].
The level of detail provided for each case is a matter of balance. In general, it is better to be brief and confine the presentation to headlines with additional detail readily available in the wings, perhaps using pre-prepared supplementary screens, if the occasion requires.

The Consultant in charge of each case should ensure that the presentation is satisfactory and fit for purpose.

NEVER EVENTS

‘Never Events’ are a construct intended to highlight serious, preventable, patient safety incidents that should rarely, if ever, occur. Surgical Never Events are those most commonly reported in the English NHS [6.5]. All Never Events must be presented and analysed at the Surgical Quality Assurance Meetings. Although, as a matter of course, they will also be identified and investigated by the Trust outside of the M&M system, it is recommended that such an event is included in the next departmental meeting. This is to capture the learning while facts and recollections are fresh in the mind, and also to ensure that the members of staff involved are still available for input.

The meeting should take into account available expert review and should formulate recommendations for the record. Many incidents will be found to have involved human factors, i.e. problems of system design and/or personal lapses/mistakes.

MORBIDITY

What constitutes ‘morbidity’ may need to be defined, but national clinical audit and registry systems will have done much of the work in this regard, and local conformity with their classifications is important for the purposes of standardisation and comparison. Frameworks such as the ‘Clavien Dindo’ system [6.6] are, available where national systems have not yet been developed. Agreement of what should be included as ‘morbidity’, and what should not, will make it easier for those charged with collecting the data.

• Examples of surgical morbidity might include:
  • Unplanned returns to theatre.
  • Readmissions within 30 days of discharge.
  • Post-operative infections (e.g. UTI, pneumonia).
  • Unplanned admissions to intensive care.
  • Wound complications (e.g. haematoma, breakdown, infection).
  • Thrombo-embolic events.
  • Complications specific to the specialty (e.g. dural laceration in neurosurgery).
Those setting data collection specifications should be aware of falling into the trap of attempting to capture all data possibly relevant for future ‘enquiries’. Against the background of a core data set, departments should prioritise, vary and focus on specific areas of concern in the light of experience. Discussion of one case, or several, sometimes identifies the need for a prospective or retrospective data review, for example, specific site infections, pressure ulcers, *C. Difficile* infections, patient trips and falls. An individual may volunteer or be tasked to lead, and the project recorded as one of the actions or outcomes of the meeting.

**SERIOUS UNTOWARD INCIDENTS (SUIs)**

Each Trust will have in place a system for reporting and investigating SUIs\(^{6.7}\). Usually, this is at a senior level in the Trust governance system, and they are invariably analysed in detail and the learning widely promulgated. This should not preclude a proactive approach being taken by the Department concerned. As is the case for ‘Never Events’, such incidents should be included in the agenda of the relevant meeting shortly after the occurrence, or at least as soon as all the facts are available. The sooner that important contributing factors are identified, and corrective actions defined and implemented, the better.

**INCIDENTS REPORTS & PATIENT FEEDBACK (COMPLAINTS)**

Trusts will already have well-developed centrally-based systems in place for collecting, aggregating and managing these. The Department of Health, in conjunction with the Royal College of Surgeons of England, issued a report in March 2014 emphasising the duty of honesty, speed of response and transparency in dealing with patient concerns\(^{6.8}\). Patient-related feedback, incident forms and the resolution of complaints should feature as a standing item on the agenda of Departmental Surgical Quality Assurance Meetings. If they are not, important indicators of quality and areas of risk will be missed.

**INAPPROPRIATE TOPICS FOR DISCUSSION**

There are substantial challenges if the major sources of learning and Quality Assurance are to be integrated into a single forum during a complete cycle of meetings. The volume of material will clearly have a bearing on the frequency and length of meetings. Short meetings incorporated into a regular, weekly, slot may be more successful than overlong meetings occurring at lengthy intervals. It is a matter for local decision.

Whatever the solution, it is essential that an overload of irrelevant material / topics/ discussion does not compromise the major purposes of the meeting. The role of the SQA Meeting in such an instance would be to identify, refer on, and then follow-up to check that the problem has been resolved.
ATTENDANCE
Attendance at the departmental Quality Assurance Meeting should be audited, and mandatory, when annual leave does not conflict. If Trusts are expected to factor in time for regular weekly or fortnightly meetings, it is incumbent upon its members to attend.

The meeting co-ordinator, or deputy, should keep a register of attendance. Attendance for only part of the meeting should be noted. Outcomes of each meeting are those of the group as a whole and carry weight only if fully endorsed by all concerned. Attendance records can be included in personal portfolios as evidence for appraisals and revalidation.
CHAPTER 7:
PREPARATION FOR THE SURGICAL QUALITY
ASSURANCE MEETING

SUMMARY

This Chapter is intended for those tasked with presenting material at an SQA Meeting, and links with Chapter 6 on Content and Programming of the Meetings.

The Chair should select cases in time for those involved to prepare their presentations.

Careful preparation is essential, if the volume of material available is to be accommodated satisfactorily within limited meeting time.

Presentations should be as brief as possible and include narrative, analysis, review of best practice and any recommendations.

Analyses should be objective, impersonal and focus on what, if anything, might have been done differently and in the future.

If a complete picture of Practice is to be acquired, it is essential that clinical audit, clinical incidents and other material, such as patient feedback from the local Patient Advice and Liaison Service, are included.

Insofar as the Surgical Quality Assurance Meeting is concerned, it is essential to bear in mind that the main purpose is to learn and improve from experience. The process may be summarised:

Evidence (Presentation of the case).
Analysis.
Agreement.
Recommendations.

• The requirements for sufficient scope, rigour, departmental ownership and limited meeting time, can be reconciled if the following approach is adopted:

• Material selected is relevant to issues of Quality Assurance and Improvement.

• Material that is to be presented and discussed is carefully prepared, so that discussions can be focused and make best use of available time and expertise.
• A wide range of material should be available for scrutiny, even if not selected prior to the meeting. In addition to case reports, **all** incidents, whether they result in harm to a patient or represent a near-miss, should be included.

• Preparation of material for presentation includes an analysis and recommendations.

• Conclusions and outcomes from the meeting are forwarded into the appropriate Trust Safety and Quality system.

**Data Collection:**
Standard forms, e.g. for mortality, can be designed to facilitate the collection and entry of data. These should not limit or place undue restrictions on the scope, content or format, nor make the collection of such data unduly time consuming and complicated. What they should do is act as a prompt to ensure that the content is sufficient for accurate analysis, such that any conclusions drawn are reliable.

A data collection form which supports an efficient framework will help to achieve this. For example, the Situation-Background-Assessment-Recommendations (SBAR) format, developed for this purpose by **Imperial College and Associates** [7.2], has been found useful.

The narrative of the case, including the investigations and actions taken, should provide a clear chronology. The relevant imaging, histopathology or microbiology results should be available for display. A brief review of the relevant literature/best practice may be incorporated into the analysis.

Presentations should finish with an analysis, conclusion and recommendations - if any. For the most part, conclusions are likely to be along the lines of ‘what might have been done differently’; whether, for example, a death or complication was avoidable/unavoidable, lessons learned, etc.

**Clinical Incidents:**
Some clinical incidents, and certainly those of a more serious nature, will merit a more sophisticated and detailed analysis than is practical at departmental level. For example, major incidents such as ‘Never Events’ and ‘Serious Untoward Incidents’ will be investigated through a specially convened panel which includes Root Cause Analysis expertise. The staff involved will be interviewed, and the results should be made available to the Departmental Quality Assurance Meeting for comment and action. It is recommended that, regardless of actions taken outside of the department, serious incidents are included in the meetings.

Distinguishing between a minor ‘incident’ and simply a less than favourable outcome may well be a matter of judgement. The
Completion of an incident form is a clear marker, which draws the attention of the Trust and Department to a perceived problem. Incident reporting forms, or copies of them, should, as a matter of routine, be sent to the Chair of the meeting for consideration for inclusion.

*Figure 1* shows a simple ‘Fish Tail’ framework that may be useful for identifying different contributing factors [7,3]. For a more detailed exposition of this methodology, and some useful guidance on the general topic of clinical incident investigation, the reader is referred to the literature and publications such as *The London Protocol* [7,3] and Professor James Reason’s text [7,4].

![Figure 1](image)

The practicality of how material is collected and fed into the SQA process is a matter for local arrangements under the supervision of the Chair. The benefits of a Trust-wide framework for data collection and presentation are clear, but this may not always be practical - certainly from the outset. The provision of a ‘Toolbox’ of meeting aids, such as forms, and ‘How to’ notes, handily situated on the Trust network, would meet the need. Such a Toolbox should be accessible for easy update by meeting Chairs. The importance of the Administrative Assistant in acting as the link to prompt, facilitate and collate between the various ‘interested’ parties can be appreciated.

It is for the Chair to supervise the detailed compilation of agendas. One option is for a short summary of the case to be submitted to the Chair of the meeting who then selects the cases to be presented. Those not selected for presentation should be visible for scrutiny at the meeting.

An agenda should be circulated. In constructing this, great care must be taken to protect patient confidentiality. Patient specific details should not be included.

It is for the presenting team, perhaps through the Administrative Assistant, to ensure that other interested staff are invited for specific presentations.
Regular clinical audit is an essential feature of any clinical quality assurance programme, and should be included regularly in the cycle of meetings. The maintenance of a personal database of activity and results is mandatory for trainees and members of staff alike, as part of the process of appraisal and revalidation. Such an exercise should not be an additional burden on data collection systems. How these data are made available for the Quality Assurance Meeting is a matter for local arrangement. Considerations that include time available and the volume of clinical activity will determine the frequency. The important point is that clinical audit is included regularly and as a matter of course.

Similar comments apply to patient feedback. Every NHS hospital will have in place a Patient Advice and Liaison Service (PALS). These departments provide the conduit for patient enquiries, complaints, surveys and a variety of other important ‘consumer’ feedback. The data that the PALS department can supply is pivotal to any quality assurance process, and are scrutinised as a matter of routine by Trust Boards and their sub-committees. As stated in previous chapters, it is essential that these be included in the departmental Quality Assurance Meeting, ideally as a fixed agenda item.
CHAPTER 8: CONDUCTING A SURGICAL QUALITY ASSURANCE MEETING

‘He that is without sin among you, let him cast the first stone…’ [8.1]

SUMMARY

The effectiveness of the Chair and the conduct of its members are pivotal to the success or failure of the SQA Meeting.

Presentations should be kept to time and discussions should not be allowed to drift.

Agendas should not be overloaded.

The approach should be professional. An attitude of constructive criticism tempered by mutual support and courtesy is to be encouraged.

It is essential that outcomes are formulated and dealt with appropriately.

A vignette of what a Surgical Quality Assurance Meeting might look like is provided in Chapter 2.

The task of the Chair is to provide effective moderation and facilitation for the meeting. Moderating any meeting is an active process. The Chair is the arbiter of all comments, discussions and criticisms. He/she will have prepared for the meeting and will conduct the agenda. The key purpose of the role is to generate interactivity and inclusivity, to defuse potential acrimony or personal attribution of blame, and to ensure that reasonable conclusions are drawn. The aim is to engender a ‘just’ and blame-free atmosphere, in which mistakes and errors can be freely discussed.

It is not the role of the Chair to provide an expert opinion on the cases presented. That is the task of the participants; particularly those involved in the case.

• Thus, the Chair should:
  • Keep focus.
  • Work to a plan.
  • Test opinions for their validity.
  • Not seek to impose his, or her, own opinions.
  • Integrate views into a consensus.
  • Ensure that the responsibility for a conclusion is shared.
The Chair should recognise when a discussion is going off-course, such that the message is being lost and time wasted. It is usually apparent when the transition from fact and evidence-based opinion drifts into myth and folklore. The Chair should be able to steer the discussion back to productive and evidence-based lessons \[8.2\]. This is essential if the learning generated during the discussion is to be captured and harnessed. It requires skill to elicit relevant contributions from a cross-section of those attending without extending discussions unduly. Good time-management is of the essence.

**Outcomes:**
The Chair should channel and refine the conclusions drawn from a discussion. The framing of such conclusions will depend on the material being considered. For example, the presentation of a case which included a complication, or series of complications, might conclude that these were unavoidable/potentially avoidable/avoidable and, if appropriate, qualify such with a brief commentary which outlines any recommendations, lessons learned, etc.

Other material, such as clinical incidents, near misses or patient complaints, will require a different format, for example, that which reflects the results of a detailed Root Cause Analysis \[8.3\].

Outcomes will be recorded in the Minutes and distributed to members of the meeting and other participants. These should be carefully screened for personal identifiable details of staff or patients before doing so. It must be clearly understood, by all present, that the content of discussions are confidential and do not leave the room.

The level of interactivity taking place during M&M meetings has been shown to have a direct impact on their educational value \[8.4\]. The educational value in Prince at al’s study was also associated with a number of variables, i.e:

- An increased level of questioning (of the audience).
- A clear explanation of the case.
- The use of slides.
- The number of questions directed to Consultants.
- The use of radiological images.

Meeting outcomes should be made available for Trust Quality Improvement Programmes. Evidence suggests that participants find the onward transmission of outcomes to a Trust safety committee or similar is acceptable, providing that the environment is non-judgemental; that the outcome information is anonymised; and that the constitution of such committees ensures adequate insight into the clinical process \[8.5\].
There are several national confidential reporting systems. The National Reporting and Learning System (NRLS) [8.6] is the generic NHS reporting system. CORESS [8.7] is designed for the use of surgical specialty teams. These systems are complementary and not mutually exclusive.
CHAPTER 9: WHO SHOULD ATTEND?

SUMMARY

In the interests of patient confidentiality and full and frank discussion, SQAs should be considered as ‘closed’ meetings.

Core membership of the SQA should be agreed within the department and an appropriate allowance included in Job Plans.

Senior nursing staff should be included within the core membership and there may be others, such as colleagues from anaesthetics or radiology.

Others will be invited from time to time, depending on the agenda.

In general, attendance by ‘spectators’ who have no involvement in the delivery of care is to be discouraged.

A register of attendance should be maintained.

Quality Assurance Meetings, as for the traditional Morbidity & Mortality (M&M) Meetings, are likely to be departmental exercises. The core membership will vary slightly, depending on the meeting content, and other staff may be invited.

PRINCIPLES

At inception, the scope and purposes of the meeting will define its core membership. Flexibility and alignment with the workings of a service is the key issue. Most Quality Assurance/M&M Meetings already operate at departmental level and attendance should be viewed as an essential element of team building and working.

The Chair should keep the core or permanent membership, which will have been agreed in broad terms by the department, under review. It is essential that, as attendance is a fixed, substantial and regular commitment, it should be written into the department workload and included in job plans.

ATTENDANCE

This is defined by role, and will vary around a core of permanent members. Generally speaking, those attending are likely to fall into one of several categories:

a. Core (attendance obligatory).

b. By Invitation.

c. Optional as of right.
REGISTER
There should be a register of attendance or part-attendance. The Chair and meeting co-ordinator should positively identify those who are not already known and, if necessary, clarify the reason for their presence. The register should include a reminder that what is said during the meeting ‘stays’ in the room and is highly confidential, although outcomes will be in the public domain. This can usefully be incorporated into the opening remarks of the Chair.

Those who cannot attend should, as a matter of courtesy, send apologies.

From the foregoing, it will be readily appreciated that it is not possible to be totally prescriptive when describing who should attend and who should not. The lists that follow are to be taken as a guide, but the principles defined earlier in this chapter should serve as a guide.

Core/Permanent Members

Clinicians
Consultant Surgeons, Physicians, Associate Specialists and Trainees.

Anaesthetists
Specialist Consultants, Trainees, Senior Nursing and Paramedical staff working in the team.

Administrator/Co-ordinator

By Invitation

Specialist Support
For example, Pathologists, Radiologists - unless permanent members.

Medical Management
For example, Clinical Director, Medical Director.

Non- Medical
Senior Management Team. For example, Director of Operations, Director of Nursing, the CEO.

Optional as of right

Medical Managers
For example, Medical Director, Clinical Director, etc.

Chief Executive Officer
CHAPTER 10: PARTICIPATING IN THE SURGICAL QUALITY ASSURANCE MEETING

“By watching the master and emulating his efforts in the presence of his example, the apprentice unconsciously picks up the rules of the art, including those which are not explicitly known to the master himself”

Michael Polyani (1958) [10.1]

SUMMARY

It is essential that those presenting are well prepared (See Chapter 7).

Training and rehearsal are helpful in this respect. Those presenting must be familiar with the equipment.

The ‘SBAR’ protocol is useful in standardising and organising presentations.

Participants are asked to be mindful of the impact of their behaviour on others.

Objectivity and honesty are essential.

These are ‘formal’, closed meetings. Their primary purpose is to determine adequate Quality Assurance and feed through conclusions into recommendations for Quality Improvement. The learning that results is an important product, and the experience of participating in such meetings should also be regarded as such. To all intents and purposes, these meetings are workshops where active participation is the norm.

The reason for re-iterating these purposes is to make clear that a high level of discipline and focus is required. In turn, this means that those presenting, conducting and participating in the meeting should be adequately prepared.

Skills:
The core membership of those attending will be expert in the technical and clinical aspects of their specialty. Discussions are enhanced if a general knowledge or awareness of Root Cause Analysis (RCA) [10.2] and the science of Human Factors (HF) [10.3] is developed by those attending. It is particularly helpful if the Chair has expertise or undertakes some training in these areas.
The Set:
It is a common experience that trainees tend to sit near the back of the room or lecture theatre and senior staff closer to the front. A more equitable distribution is to be encouraged. This is something that the Chair might like to address from the outset.

Where possible, when participants are not on-call, the meeting should be regarded as protected “bleep-free” time. It is important that pagers and phones are set to silent/vibrate mode or switched off.

The Chair:
The duties of the Chair are covered in Chapter 4 and the conduct of the meeting in Chapter 8.

The Presenter:
It is essential for success that presentations are clear, succinct and delivered efficiently. Time management is essential. There is no substitute for preparation (see Chapter 7) and rehearsal. The presenter should be familiar with the equipment to be used. A framework such as ‘SBAR’ [10,41] is ideal for both preparation and ease of presentation, and is highly recommended.

In the interests of developing presentation skills, it is likely that trainees will deliver most presentations. However, it is unreasonable to expect participants to sit through overlong, poorly-prepared presentations that are unrehearsed and badly delivered, by presenters who have not been provided with training in this respect. It is a matter for the consultant concerned to ensure that the presentation of cases for which he/she is responsible is carried out to a reasonable standard.

It is outside the scope of this guide to provide detailed guidance on these skills. Attendance at a Royal College or local ‘Training the Trainers’ course, or equivalent, is invaluable and can be undertaken at an early stage in training.

Audience Participation:
For those attending, it is important to bear in mind throughout that it is the interests of the patients and service that come first, and that honesty and objectivity are vital if the meetings are to be productive. It is the duty of participants to ensure that all the facts are made known, that decisions relevant to the case are subjected to scrutiny and that appropriate conclusions are drawn, however unpalatable they may be on occasion.
**Behaviour:**
Those presenting are expected to:

- Maintain confidentiality.
- Prepare thoroughly in advance.
- Arrive on time.
- Answer questions directly and honestly, acknowledging error/ignorance as appropriate.
- Avoid confrontation.
- Behave in an open and constructive manner.

**The Administrative Assistant:**
This most vital role is described more fully elsewhere in this guide. Before the meeting, the Administrative Assistant, or equivalent, should have opened the facility in good time and ensured that equipment is in working order. A register should have been prepared and should be signed by all who attend. The Assistant should note part-attendances and visitors who should be asked to produce identification and satisfactory reasons for being included.

During the meeting, queries concerning data or similar may arise, and it is important that the Assistant remains in attendance.

Upon completion of the meeting, time should be allowed for the Assistant to meet with the Chair for a debriefing and to agree post-meeting actions. Any paperwork or electronic material should be safely removed and dealt with appropriately.
CHAPTER 11:
SUPPORT FOR THE SURGICAL QUALITY
ASSURANCE MEETING

SUMMARY
In addition to leadership by an effective Chair and Administrative Assistant (see Chapters 4 and 5), the Surgical Quality Assurance Meeting requires:

- Allocation of time in timetables.
- A meeting room that is quiet, suitably located, well-ventilated, and has controlled lighting.
- An adequate supply of suitable furniture.
- Appropriate presentation aids.
- Access to adequate IT support.

Managing quality assurance close to the clinical interface, as suggested in this guide, may require additional support. Without minimal allocation of resources, the Surgical Quality Assurance Meeting will not function satisfactorily. These include:

- Time.
- Appropriate venue.
- Seating.
- Administrative support.
- Presentation aids.
- IT access.

Time:
For professional activities, such as attendance at clinical meetings, time is included in every surgical job plan.

The amount of time that is required will depend upon the frequency of meetings and their length. A weekly meeting, one hour long, should be adequate for most Surgical Departments. It can be included as teaching time for medical students and trainees.

The Meeting Room:
Space is at a premium in most Trusts, and a satisfactory solution may require some imagination. Without appropriate space, the SQA Meetings are likely to be unsatisfactory. In order to minimise noise, a quiet location at some distance from the central hub of the
Trust has its attractions, although a room that is central, perhaps on or near a ward, makes it easier for busy clinical staff to attend. A lecture theatre or small seminar room in a teaching facility is ideal for most departments

**Seating:**
It may seem a trivial consideration, but chairs that facilitate note taking are an improvement over those without. Considerations such as storage, flexibility of use, expense, durability and comfort will, no doubt, also come into the reckoning. It is important to secure accommodation, seating, and other fixtures, which facilitate - rather than limit - the room’s use as a meeting/teaching facility.

**Presentation Aids:**
Access to a modern, well-equipped lecture theatre is ideal. Full kit may include projectors, monitors, sound, interactive screens, transparency/hard copy projectors and real-time links to the Trust network for imaging and pathology material. Video links can enable participation of distant, regional groups where small highly specialised units are concerned.

PowerPoint® projection, or similar, is ubiquitous and has largely superseded the overhead projector (OHP) and transparencies.

Flip charts are useful for keeping a record, formulating recommendations and summing up at the end of the meeting. Interactive whiteboards, from which notes can be electronically transferred, are ideal.

Reliability is an important consideration and resilience should be built into whichever solution is adopted. Staff using equipment should be familiar with its workings. Rehearsal should be encouraged and, for this reason, it is helpful if access to the room/lecture theatre is easily available outside of the meeting.

Adequate preparation will overcome problems with UHB memory stick encryption, system passwords, ‘crashed’ laptops, failed projectors and the like.

Conversely, a slick, well prepared, presentation, delivered on time and with panache, can convey a maximum amount of information in the minimum of time. It is particularly important that trainees acquire presentation skills and, in this respect, the Quality Assurance Meeting is a useful training ground. A good Chair or consultant trainer will be able to provide a trainee with useful formative feedback.

Ultimately, it is the Chair’s overall responsibility, probably through the Administrative Assistant, to ensure that satisfactory projection equipment is available and ready to go at the start of each meeting;
it is the presenter’s responsibility to make sure that their presentation:

- Is loaded in timely fashion.
- Commences on time and without fuss.
- Is clear.
- Is succinct.
- Is fit for purpose.
- Finishes within the allotted time.

**IT Systems Access:**
As most Trusts have developed increasingly sophisticated electronic systems for data storage and retrieval – notably X-rays and scans – access in real time at Quality Assurance Meetings is becoming practical and should be considered. Unfortunately, increased complexity often turns out to have a downside in terms of reliability. Where specialties operate over a broad geographical area, video conferencing facilities are becoming more widely used and effective.
CHAPTER 12:
PROBLEMS LIKELY TO BE ENCOUNTERED IN CONDUCTING SURGICAL QUALITY ASSURANCE MEETINGS

SUMMARY

An effective Surgical Quality Assurance Meeting will not work without the full support of its leaders (i.e. Consultant Surgeons).

Resourcing an Administrative Assistant to provide the data, other clinical content, and general support for the process is crucial.

Difficulties of obtaining necessary resources are not to be under-estimated. Where substantial change is required, problems will inevitably arise; especially in the face of hard-pressed budgets and managers who may have other priorities.

This section discusses some of these problems and approaches that may help to resolve them. The key points for success are:

- Determination on the part of the Department to take ownership of the quality of surgical care delivered.
- Adoption of the principles outlined in this guide.
- Leading changes necessary for improvement.

Context:
Effective Quality Assurance Meetings can only be achieved by taking a disciplined and professional approach to the way in which they are arranged and conducted. In what follows, readers will recognise some of the obstacles to the satisfactory conduct of meetings in general. Remediating some of these may not be easy, and will require strong leadership. It will fall mainly to the Chair, supported by his/her Clinical Management and colleagues, to identify and facilitate solutions. The appraisal and revalidation system is intended, among other things, to address refractory problems of compliance.

Evaluation:
A planned evaluation of the meetings after an initial period of experience may provide a useful opportunity to review how they are working, plan the next cycle and address any operational problems that have arisen.
The Poorly Performing Chair:
The Chair (cf. ‘Clinical Governance Lead’) should be appointed by the consultant body of the department. This is a key appointment, and will largely determine whether the programme succeeds or fails. If, after a period, it becomes apparent that the Chair is not up to the task, then action should be taken. The process should be active and not one that is allowed to drift. A planned review/appraisal with the Clinical Director, suitably informed by feedback from colleagues, should be factored into the programme as a matter of routine.

The Habitual Non-Attender:
Attendance is a contractual obligation for ‘core’ members. Unless there are exceptional circumstances, habitual non- or part-attendance should be taken seriously. It sets a poor example to other members, and degrades the quality of meetings. It is for the Chair to attempt resolution through discussion and provide help with resolving any underlying structural problem, such as timetabling issues. If this fails, then it becomes a matter for the Clinical Director and Trust, using the same mechanism as for non-attendance at fixed clinical sessions.

The Habitual Part-Meeting Attender:
As for habitual non-attendance.

The Poorly Prepared:
If this is a consistent pattern of behaviour, the Chair should take action. Feedback should be provided in the first instance and escalated into a more formal process if matters do not improve. It is important that any meetings of this nature are concluded with a note of what has been discussed and the way forward that has been agreed. A letter *post hoc* to those involved is usual practice in similar situations.

Unacceptable Behaviour During Meetings:
Surgeons are not unknown for holding strong views and generally being keen to share them with peers. All understand that there may be the occasional minor lapse in civility or the tenor of a remark, especially during heated debate. But there is a line that must not be crossed. Verbal bullying or overbearing behaviour needs to be suppressed. A quiet word in private may be all that is needed. If not, further action may be taken outside of the meeting.

It is not within the remit of this guide to offer advice on the techniques for controlling meetings. This skill should be one of the attributes which guide suitable appointment to the role of Chair.

The Role Model:
The importance of professional behaviour during these meetings, and the impact upon junior and other staff cannot be over-stated.
Well run and moderated, an SQA Meeting can be an excellent demonstration of team working and professional behaviour, whilst bad tempered or ill-moderated meetings represent exactly the opposite. The impact of the conduct of seniors in shaping the attitudes and future behaviour of those whose training is in their charge, is not always appreciated [12,1].

**Competence Issues:**
Such issues may, for example, include a clinician with consistently substandard results. There are several mechanisms through which consistently substandard performance can be picked up and appropriately handled. The Surgical Quality Assurance Meeting has an important role in this respect. For this reason, it is important that clinical audit is part of its remit. Whatever arrangements are put in place, there must be no doubts concerning accuracy and completeness of data entry. The role of the meeting is not to attribute blame or cause, but, should apparently substandard results be identified through the SQA Meeting, the matter must be investigated and appropriate action taken as a matter of urgency. This will occur outside of the meeting and will involve the Clinical Director.

Most surgeons contribute to a national specialty database for the purposes of Clinical Audit. Clinical performance is reviewed as part of a surgeon’s annual appraisal portfolio. Data collection for this exercise is mandatory. The publication by the Department of Health of individual surgeons’ results in November 2014 has no doubt provided further weight to the importance of recording clinical outcomes and making sure that other variables, such as case-mix and co-morbidity, are included. The practicalities of how such data capture is achieved will vary between Trusts, and has implications for existing arrangements and IT systems. Given suitable arrangements are in place to guard against data manipulation, there is a compelling case for clinical data entry and verification to be devolved down as a departmental responsibility. Such an arrangement will comply with the requirements of a departmental Quality Assurance Meeting as well as those of the Clinical Director, and may have benefits in terms of data verification and coding.

The role of the Quality Assurance Meeting can be summarised as:

- Monitoring standards.
- Raising any concerns.
- Ensuring that any actions taken are effective.

Safety of patients is the first and foremost consideration, and prompt definitive action must be taken at the first signs of incompetence or any other indicators of substandard performance.
The Serious Untoward Incident, Never Event or Similar:
Serious mistakes and errors will occur, regardless of the quality of staff and the excellence of the systems that are in place, but they should be increasingly rare. Such incidents must be reported to Trust management through specific reporting systems which Trusts are obliged to have in place. From the point of view of the Surgical Quality Assurance Meeting, however, there is no reason to treat these in any way differently from other morbidity or mortality. Such incidents will be subject to widespread scrutiny outside of the department and its Quality Assurance Meeting, and are likely to be very uncomfortable for those concerned. Accordingly, it is important that these situations are handled with particular sensitivity and empathy.

The Reluctant Trust (Lack of Support and Resources):
The minimum facilities required to run an effective M&M meeting are described in the preceding chapter. In essence these are:

- A suitably equipped room.
- Administrative support.
- Allocated time.

In return for this, the Trust is entitled to expect that the meetings will:

- Be well run.
- Be well attended.
- Produce effective learning for those attending.
- Produce well-reasoned outcomes.
- Provide reliable quality assurance.
- Provide practical suggestions for quality improvement.
- Maintain written records.

A problem for NHS Trusts is that they have limited and often diminishing resources that are already fully allocated. It will be for surgeons and their teams to decide whether they wish to adopt the package of standards outlined in this guide and, if so how, they set about working with their Trusts to achieve them. The following general approach is, therefore, recommended:

1. Be clear what is needed – ‘The Vision’.
2. Be clear why it is needed.
3. Be clear how it can be achieved.
4. Negotiate and lead incremental change.
Steps 1 and 2 are described in this guide, and hopefully accord with the ambitions of surgeons and their teams at whom it is directed.

Step 3 is dependent on local circumstances. In today’s highly bureaucratic system, it is likely to require the submission of a proposal and supporting business case. This is a useful exercise, as it prompts discussion and encourages clarity of vision.

Step 4: A well-written proposal and business case requires a response from the Executive. If the Trust is unwilling or unable to support the package, it will be for the Department to decide how it wishes to proceed. This will depend on the nature of the response. It may be that the Trust and its Medical Director have other views on how surgical quality assurance is to be achieved or are willing to resource only part of the package. It is not practical to cover every eventuality in these notes. Any objections will need careful scrutiny and pursuit through dialogue and negotiation. Principles of clinical leadership, ownership, support and engagement are paramount.

In the face of impasse, it is for the department to decide, as a group, whether it wishes to remain with the status quo, pursue a compromise solution, seek resourcing from elsewhere or conduct meetings outside of working hours.
CHAPTER 13: EVALUATING THE GOOD SURGICAL QUALITY ASSURANCE MEETING

“Everything that can be counted does not necessarily count; everything that counts cannot necessarily be counted.”

Albert Einstein

Evaluation ‘…the making of a judgement about the … value of something’

Oxford English Dictionary

SUMMARY

Regular review of the SQA Process should be built into the programme of meetings.

Evaluation should include any evidence of the impact of the Programme on Quality and Improvement, or otherwise.

Feedback from those involved is essential.

Frameworks have been developed and can be adapted for use in this exercise.

A checklist is included as an appendix to this guide.

The management of any project should include a regular review and evaluation. It is part of a cycle comprising:

- Planning.
- Implementation.
- Review and Evaluation.

It is recommended that surgical departments build in such a review and formal evaluation of their Quality Assurance Meetings. The timing is a matter for local consideration. For most, the implementation of the ideas and suggestions in this guide will be a gradual process, and it is unlikely that one size will fit all. Nonetheless, taking the principles and spirit contained therein, and comparing them to what is being achieved or otherwise, should be a useful exercise. A starting point could be:

- What is working well?
- What needs improvement?
- Are the objectives of the exercise being met?
- What evidence is there that the Meetings are being effective?
Whichever approach is taken, reliable feedback is essential. Working lives are very busy, and detailed questionnaires which entail yet more paperwork and time in front of a computer will not be welcome. Perhaps circulating an evaluation/feedback form during a meeting will be all that is needed from participants? Perhaps a discussion during a department business meeting will bring in other views? The net should be cast as widely as practical, without overburdening colleagues.

To gauge the overall effectiveness of the meetings, it may be worth considering one of the established models of evaluation, such as a modified version of Kirkpatrick’s framework:

1. **Reaction:**
   Have participants reacted favourably to the changes? If so, to what extent?

2. **Learning:**
   To what degree have participants acquired the intended knowledge, skills, attitudes, confidence and commitment as a result of the Meetings/Exercise?

3. **Behaviour:**
   To what degree are participants applying what they have learned?

4. **Results:**
   To what degree have the intended outcomes been achieved?

The results should be fed back to the meeting and other parts of Trust-wide systems, perhaps as part of a periodic report. A favourable evaluation will demonstrate, to all concerned, that effective clinical governance is in place and provides a further opportunity to share learning.

The ‘**Evaluation Checklist**’ outlined in Appendix 4 may be helpful.
### APPENDIX 1: EXAMPLE JOB DESCRIPTION FOR THE CHAIR OF THE SURGICAL QUALITY ASSURANCE MEETING

<table>
<thead>
<tr>
<th>ATTRIBUTE/SKILL</th>
<th>ESSENTIAL</th>
<th>DESIRABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chairing Skills</strong></td>
<td>A track record of conducting successful open discussions/meetings.</td>
<td>Highly successful Chair.</td>
</tr>
<tr>
<td><strong>Analytical Skills</strong></td>
<td>An awareness of Root Cause Analysis techniques.</td>
<td>Formal Training in Root Cause Analysis techniques.</td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
<td>Track record of successful team leadership.</td>
<td>Track record of successful clinical leadership at senior level.</td>
</tr>
<tr>
<td><strong>Presentational Skills</strong></td>
<td>Familiarity with basic IT presenting equipment.</td>
<td>Training in presentational and communication skills.</td>
</tr>
<tr>
<td></td>
<td>Track record of delivering professional presentations.</td>
<td></td>
</tr>
<tr>
<td><strong>Professional</strong></td>
<td>‘Completer-Finisher’ personality.</td>
<td>Record of involvement in higher order professional activities such as College or DoH work.</td>
</tr>
<tr>
<td></td>
<td>High professional standards.</td>
<td></td>
</tr>
<tr>
<td><strong>Commitment</strong></td>
<td>Demonstrable involvement in Patient Safety or Clinical Governance systems.</td>
<td>Leadership of Patient Safety projects.</td>
</tr>
<tr>
<td><strong>Networking Skills</strong></td>
<td>Local Knowledge of the Trust and the relevant Trust wide systems.</td>
<td>Active and successful involvement in the leadership and/or management within the Trust.</td>
</tr>
</tbody>
</table>
APPENDIX 2:
EXAMPLE JOB DESCRIPTION FOR THE
CLINICAL GOVERNANCE SUPPORT
ADMINISTRATOR

<table>
<thead>
<tr>
<th>ATTRIBUTE/SKILL</th>
<th>ESSENTIAL</th>
<th>DESIRABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Management</td>
<td>Good clerical skills</td>
<td>Excellent clerical skills i.e. IT data entry, typing, able to manage basic spread sheet applications.</td>
</tr>
<tr>
<td>Personality</td>
<td>Friendly, co-operative and efficient.</td>
<td>Successful leadership experience.</td>
</tr>
<tr>
<td>Initiative</td>
<td>Able to work with minimum supervision.</td>
<td>Track record as a competent problem solver.</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>Excellent team player.</td>
<td>Proven networking skills.</td>
</tr>
<tr>
<td>Work Ethic</td>
<td>Completing/finishing approach to problems and the workplace.</td>
<td></td>
</tr>
<tr>
<td>Communication Skills</td>
<td>Able to write satisfactory minutes of meetings.</td>
<td>Previous experience of minute taking and production.</td>
</tr>
<tr>
<td>IT</td>
<td>Familiarity with IT and presentational equipment.</td>
<td>Expertise with presentational and IT/computer equipment.</td>
</tr>
</tbody>
</table>
APPENDIX 3:
SITUATION, BACKGROUND, ASSESSMENT AND RECOMMENDATION (SBAR) FRAMEWORK

SBAR is a framework which helps communication by structuring the conversation. It encourages the communicator to be succinct and avoid repetition. It was initially developed for the military and aviation, but was modified for clinical use by Dr M Leonard, for Kaiser Permanente, Colorado, US.

It is a tool that can be used at practically any point during the patient journey, including GP referral letters, intra-hospital communication between healthcare professionals and discharge letters. It is intended to end the culture of ‘hint and hope’, and to replace it with clear, unambiguous communication. It is equally applicable to the discussions held in the Surgical Quality Assurance Meeting.

| S | Situation  
Give a succinct overview of the event, which includes setting, patient, team and the equipment involved. |
| B | Background  
Summarise the significant factors – what brought us to this point? ‘Context’. |
| A | Assessment  
Summarise the facts. Analysis; why do you think this or that happened? |
| R | Recommendations  
What needs to change? What are the lessons? |
An example of how the SBAR framework may be used in an M&M meeting.

<table>
<thead>
<tr>
<th>S</th>
<th>Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A 45-year old male underwent revision mastoid surgery. The facial nerve monitor was in place. The operating surgeon was an ST7 surgical trainee under the direct supervision of a Consultant surgeon. A Grade 6 Facial palsy was noted in the recovery suite. On re-exploration, the facial nerve was found to have been transected.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>Background</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The volume on the monitor had been turned down by the previous operating team, and positioned out of view of the operating surgeon and supervisor.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The operating and supervising surgeons were overly reliant on the monitor to warn of impending facial nerve injury.</td>
</tr>
<tr>
<td></td>
<td>The volume setting had not been included as part of the pre-operative checks.</td>
</tr>
<tr>
<td></td>
<td>The monitor had been incorrectly positioned out of the sight of the operating surgeons.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>R</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The monitor to be used as an aide, not as a substitute for careful anatomical dissection.</td>
</tr>
<tr>
<td></td>
<td>When used, critical equipment such as the monitor should be included and checked during the pre-operative (WHO) checklist.</td>
</tr>
<tr>
<td></td>
<td>Suggest to the manufacturer and regulators (Medicines and Health care products Regulatory Authority – MHRA) that, even at minimum volume setting, the warning of critical equipment remains audible.</td>
</tr>
<tr>
<td></td>
<td>Submit an incident report to CORESS or NRLS.</td>
</tr>
</tbody>
</table>
**APPENDIX 4: AN EVALUATION CHECKLIST**

This is a quick ‘Evaluation Checklist’ which can be used to evaluate specific criteria of the SQA; it can be adapted to suit specific details of the meetings. Data could be collected at each meeting to review progress over a period of time, or it could be collected periodically, i.e. this checklist can be used as an audit tool.

‘Yes’ is considered good practice; ‘No’ is a prompt for further attention.

‘No’ responses are self-explanatory and will help focus efforts to improve.

<table>
<thead>
<tr>
<th>TOPIC AREA</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attendance</strong></td>
<td></td>
</tr>
<tr>
<td>Attendance record maintained</td>
<td></td>
</tr>
<tr>
<td>Over 70% of consultant surgeons in attendance</td>
<td></td>
</tr>
<tr>
<td>Over 70% of trainees in attendance</td>
<td></td>
</tr>
<tr>
<td>Other specialties/individuals in attendance (attach a list)</td>
<td></td>
</tr>
<tr>
<td><strong>Chair</strong></td>
<td></td>
</tr>
<tr>
<td>There is a named Chair responsible for the meetings</td>
<td></td>
</tr>
<tr>
<td>The meeting is chaired effectively</td>
<td></td>
</tr>
<tr>
<td>Minutes of the previous meeting are reviewed</td>
<td></td>
</tr>
<tr>
<td>Outcomes of the meeting are disseminated</td>
<td></td>
</tr>
<tr>
<td><strong>Administrative Support</strong></td>
<td></td>
</tr>
<tr>
<td>There is a named Administrative Assistant</td>
<td></td>
</tr>
<tr>
<td>The details of the meetings are communicated sufficiently far in advance</td>
<td></td>
</tr>
<tr>
<td>Meeting agendas are prepared and circulated in a timely fashion</td>
<td></td>
</tr>
<tr>
<td>Data collection and availability is satisfactory</td>
<td></td>
</tr>
<tr>
<td>Data is complete and accurate</td>
<td></td>
</tr>
<tr>
<td>Data security is satisfactory</td>
<td></td>
</tr>
<tr>
<td>The Minutes are satisfactory and disseminated securely and in a timely fashion</td>
<td></td>
</tr>
<tr>
<td>The Administrative support has been adequate</td>
<td></td>
</tr>
<tr>
<td>The performance of the Administrative Assistant is satisfactory</td>
<td></td>
</tr>
</tbody>
</table>
### Structure
The meeting occurs every *week/fortnight/month*

The room is comfortable and fit for purpose

The meetings start and finish on time

### Content
All cases of mortality are discussed

All Never Events and Clinical Incidents are discussed

Selected Morbidity is discussed

Clinical Audit is presented

Specific criteria are used for choice of cases

### Presentations
In the round, case presentations work satisfactorily (e.g. structured, prepared, presented well)

Other material presented satisfactorily (e.g. clinical incidents, audit material, patient feedback, etc.)

Content is discussed and analysed effectively

### Outcomes
Outcomes are documented and disseminated in a timely fashion

All planned projects have a time scale for completion

Actions and projects resulting from discussions are ‘owned’ and seen through to completion

Completed projects are presented

Learning outcomes are disseminated appropriately

### Culture
Open discussion is encouraged

There is a constructive approach to analysis, conclusions and recommendations

The majority of those attending contribute to discussions
APPENDIX 5: CORESS BOARD OF TRUSTEES

Lord Bernard Ribeiro, CBE, FRCS
Chairman
(Past President, Association of Surgeons of Great Britain and Ireland)
(Past President, Royal College of Surgeons of England)

Mr Denis Wilkins, FRCS
Surgical Member
(Past President, Association of Surgeons of Great Britain and Ireland)

Miss Clare Marx, CBE, PRCS
Surgical Member, representing the Royal Surgical Colleges
(President, Royal College of Surgeons of England)

Mr Adam Lewis, CVO, FRCS
Surgical Member
(Founding CORESS Programme Director)

Mr Andrew May, FRCS
Surgical Member

Mr Peter Tait
Lay Member
(Former Chief Executive, CHIRP - Confidential Reporting for Aviation & Maritime Communities)

Mr Martin Else
Lay Member
(Former Chief Executive, Royal College of Physicians)

Professor Nicholas P Gair
Lay Member
(Chief Executive, Association of Surgeons of Great Britain and Ireland)

IN ATTENDANCE

Professor Frank Smith
CORESS Programme Director
REFERENCES

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Advances in Patient Safety: New Directions and Alternative Approaches 2: Culture and Redesign
Agency for Healthcare Research and Quality (US); 2008 Aug
http://www.ahrq.gov/qual/advances2/

1.4 http://www.gmc-uk.org/guidance/good_medical_practice/systems_protect.asp
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1.5 www.midstaffspublicinquiry.com/
(2013)
Executive Summary. 76, Para 1.184

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Executive Summary. 8-9, Para 4

1.7 Nursing and Midwifery Council
The Code: Standards of conduct performance and ethics for nurses and midwives
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2.1 Reason J
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2.4 Benn J, Koutantji M, Wallace L et al
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3.2 www.coress.org.uk

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4.1 Gordon L A
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6.3 http://www.institute.nhs.uk/building_capability/general/lean_thinking.html
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8.5 Higginson J, Walter R, Fulop F
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Chapter 10:

10.1 Polyani M

*Personal Knowledge: Towards a Post-Critical Philosophy*
University of Chicago Press (1958)

10.2 For an account of Root Cause methodology go to:
www.institute.nhs.uk/quality_and_service_improvement_tool

10.3 For an outline of many aspects of Human Factors and their application in healthcare go to:
http://chfg.org

10.4 www.institute.nhs.uk/quality_and_service_improvement_tools

Chapter 12:

12.1 Polyani M

*Personal Knowledge: Towards a Post-Critical Philosophy*
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Chapter 13:

The Confidential Reporting System for Surgery (CORESS) is an independent charity, founded by ASGBI, which aims to promote safety in surgical practice in the NHS and the private sector.

The charity receives confidential incident reports from surgeons and theatre staff. These confidential reports are analysed by the CORESS Advisory Committee, who make comments and extract lessons from these events. CORESS then publishes these reports alongside the Advisory Committees’ safety lessons in the surgical literature to educate fellow surgeons, and to reduce the chances of a similar incident re-occurring in another theatre. CORESS disseminates this information to all interested parties including, where relevant, administration staff, manufacturers, packaging companies, etc.

CORESS aims to educate, rather than blame, and it serves all surgical disciplines. Some of its key features are:

• Analysing safety-related reports which would not otherwise be available.
• At all times keeping the identity of the reporter confidential.
• Publishing reports widely in surgical literature to educate surgeons and other theatre staff.
• Hosting training courses on safer surgical practice and human factors.

CORESS was founded in 2005, by the then President of ASGBI Mr Denis Wilkins, along with other interested parties. This publication thus marks the 10th Anniversary of CORESS.

For further information, please visit:

www.coress.org.uk
Association of Surgeons of Great Britain and Ireland

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