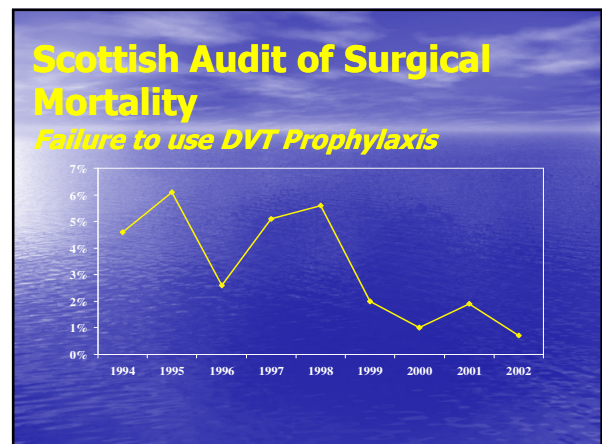
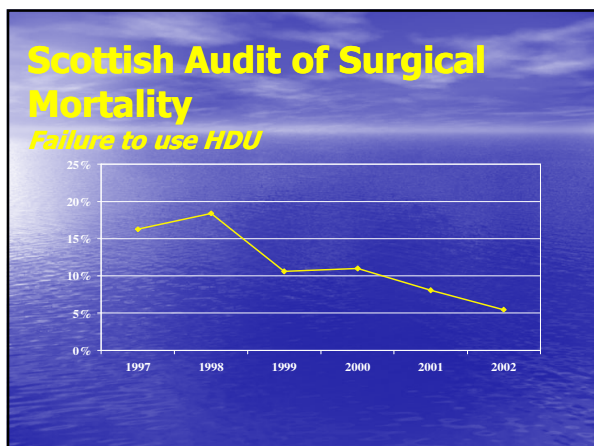


2008 Interim Annual Report: Table 2: Assessors' statements about the management of patients

Management of case	2008	2007
No areas of concern or for consideration	2,016	2,359
Areas for consideration but they made no difference to the eventual outcome	192	268
Areas of concern but they made no difference to the eventual outcome	63	62
Areas of concern which may have contributed to patient's death	86	137
Areas of concern which caused death	2	11





2008 Annual Report: Table 1: Consultant involvement

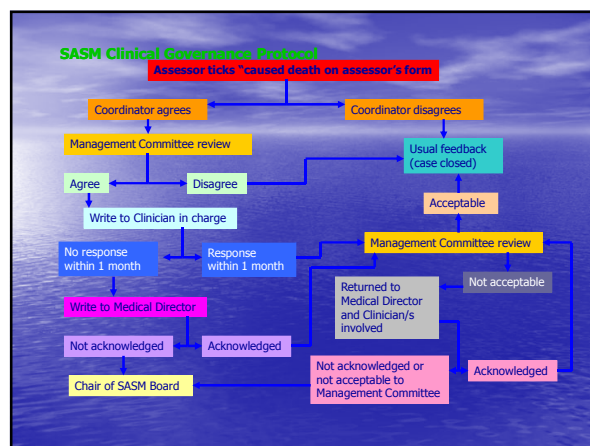
	2008	2007	2006
Consultant deciding operation was required	99%	99%	98%
Consultant surgeon present in theatre	83%	82%	82%
Consultant anaesthetist present in theatre	84%	81%	78%

Table 3: Most common ACONs

Incident type	2008	2007
Inappropriate placement of patient on surgical ward	26	17
Inappropriate operation should not have been done	19	28
Delay in referral by non surgical hospital speciality	15	20
Transfer of patient not have occurred	15	21
Inappropriate hospital resource (e.g. Palliative Care/GI service)	15	7
Wrong diagnosis, another team	14	22
Communication failure between teams	13	27
Contamination/urinary infection	11	14
WBCA infection	11	13
Anastomotic leak	10	14
Communication failure between staff	10	19
Failure to investigate the patient appropriately	9	6
Fluid overload post operatively	9	8
Poor quality fluid balance post operatively	9	15
Failure/delay to utilise HDU	9	11
Delay to surgery, unspecified	8	23
Hypotension during regional anaesthesia	8	3
No HDU bed available at time of need	8	5



Integrate into local Clinical Governance processes

- ### Local integration
- Morbidity and mortality meetings
 - Anaesthesia in Glasgow
 - Surgery
 - Multidisciplinary meetings
 - some resistance
 - review process of care
 - feedback
 - Appraisal process: Medical Director, SCMO



SASM

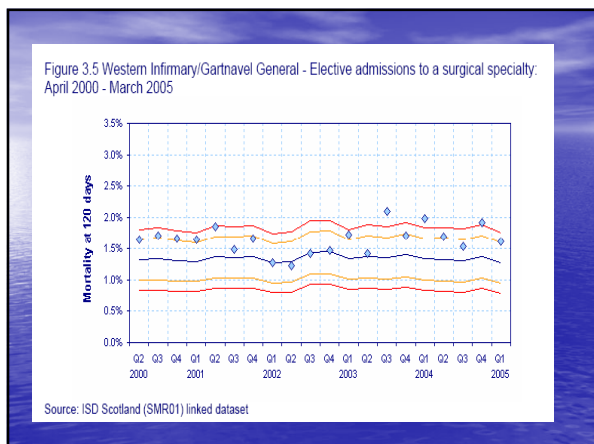
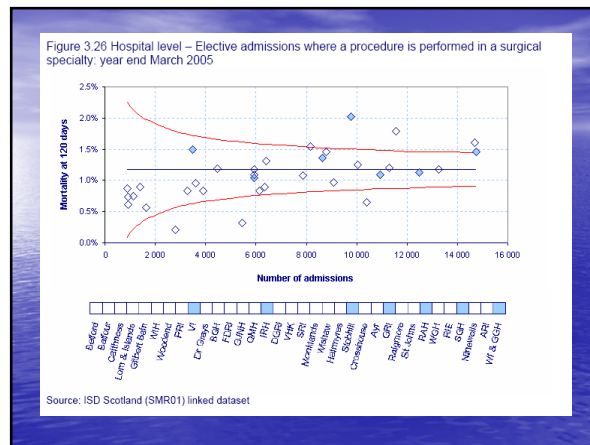
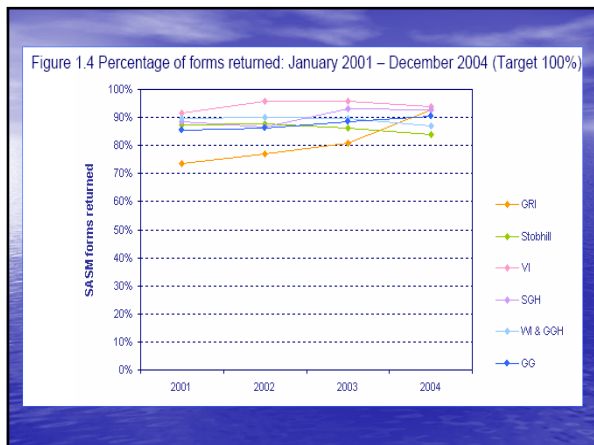
- Individual feedback
 - Case by case
 - Individual annual report (IAR)
- National annual report
- Health Board report
- Case report book
- Surgical profiles

Surgical Profile

Greater Glasgow and Clyde

November 2006



How surgical data should be used

- Cannot be used in isolation to make reliable judgments about quality or performance
- Death rates unreliable
- Cannot be adequately corrected for confounders
- Draw attention to areas worthy of further investigation
- Learning and improvement in quality

