

clinical governance structure of NHS Tayside reflected this introduction of clinical governance with clinical services arranged into clinical governance groups to oversee these activities within their departments.

As well as an overarching Tayside NHS Board clinical governance approach through organisational clinical governance strategies and structures, NHS Tayside operated a system in which there were clinical governance committees for all the clinical groups in the acute division. These local, service-level groups had accountability for the management and delivery of clinical governance activity and were responsible for escalation of concerns through the clinical governance structure. For neurosurgery, this was the clinical governance committee for specialist services group. Significant concerns should be escalated through to the clinical governance committee of Tayside NHS Board which, at the time, was the Improvement and Quality Committee.

Reporting and recording of clinical safety incidents

In 2012, NHS Tayside introduced its Significant Event Management Policy, which replaced the Adverse Incident Management Policy. The Datix electronic recording system was also introduced in 2012 as a method to record adverse incidents. Prior to this there was no electronic system and it has therefore not been possible for the review team to gather examples of incidents reported prior to 2012.

This new policy introduced the use of Significant Clinical Event Analysis reviews for all Amber and Red Category 3-5 events (moderate, major and catastrophic). Significant Clinical Event Analysis reviews (SCEA) were chaired by the Medical and Nurse Director and operationally managed by the Clinical Governance Corporate team. SCEA reviews resulted in a report with actions delegated to services to implement.

Clinical Governance Strategy and Assurance Framework

From 2013, NHS Tayside Clinical Governance was conducted in accordance with its Clinical Governance Strategy 2013-2016, which was published in November 2013. The strategy detailed the Assurance Framework for Clinical Governance. NHS Tayside's Clinical Governance Team regularly updated and reviewed its guidance and policies in relation to Adverse Event Management, and the Clinical and Care Governance Strategies from this point.

Mortality and Morbidity (M&M) meetings

Mortality and Morbidity (M&M) meetings for clinical groups were introduced across NHS Tayside more than 20 years ago, with the neurosurgery meeting established in 2000. These were the fora where attendees discussed clinical cases, including complications following surgery on a quarterly basis. M&M meetings were run on the foundation that cases brought forward for discussion were dependent on individual consultants highlighting complications and being prepared to discuss their practice openly with colleagues in line with the GMC's Code of Conduct 'Duties of a Doctor'.

Complaints and Feedback

3. Internal Signals in NHS Tayside of Concerns in Clinical Practice

Why are we looking at this?

Following the work undertaken to understand the extent and capability of the systems which were in place to monitor concerns in clinical practice as described in the previous section, the review team looked at the information in these systems relating to Professor Eljamel. In particular they looked at the data which NHS Tayside still holds to see how these systems had, or had not, alerted the organisation to any potential concerns or difficulties relating to the surgeon's clinical practice.

The review has assessed the data and information held in each of these monitoring systems to try to ascertain the extent to which the organisation was aware of any escalating concerns.

What the due diligence review found:

Clinical Governance

Board and local service structures

There is no data or information identified which informs the review that there were any concerns discussed or escalated relating to Professor Eljamel either at local service level or Tayside NHS Board assurance committee level which would have been the Improvement and Quality Committee. Prior to 2013/2014, the Board only received general reports about individuals from the time they were suspended.

Reporting and recording of clinical safety incidents and Clinical Governance Strategy and Assurance Framework

Only two of the 98 complaints received relating to Professor Eljamel were registered as adverse incidents, with only one of these formally documented as a Significant Clinical Event Analysis review. In addition, only two issues appeared to be detected by internal monitoring arrangements and, of these, only one was investigated in accordance with the clinical governance policies in NHS Tayside.

Mortality and Morbidity (M&M) meetings

The review has not identified any documentation from M&M meetings, nor any other internal documents from internal monitoring meetings that raised concerns about Professor Eljamel. There is also no evidence identified in which he himself highlighted complications in any of his own cases for discussion with colleagues in line with the intended purpose of M&M meetings and also as set out in the GMC's code of conduct 'Duties of a Doctor'.

Complaints and Feedback

The review found that there is a total of 98 complaints relating to Professor Eljamel's practice in Tayside.

The caveat the review team places on this is explained at the Complaints and Feedback section on page 8 which details the impact of the decommissioning of the legacy AIM complaints recording system.

This means that it is not possible to report how many complaints were received prior to 2012 when the AIM system transferred to the current Datix data system.

Table 1. Summary of complaints and routes to resolution

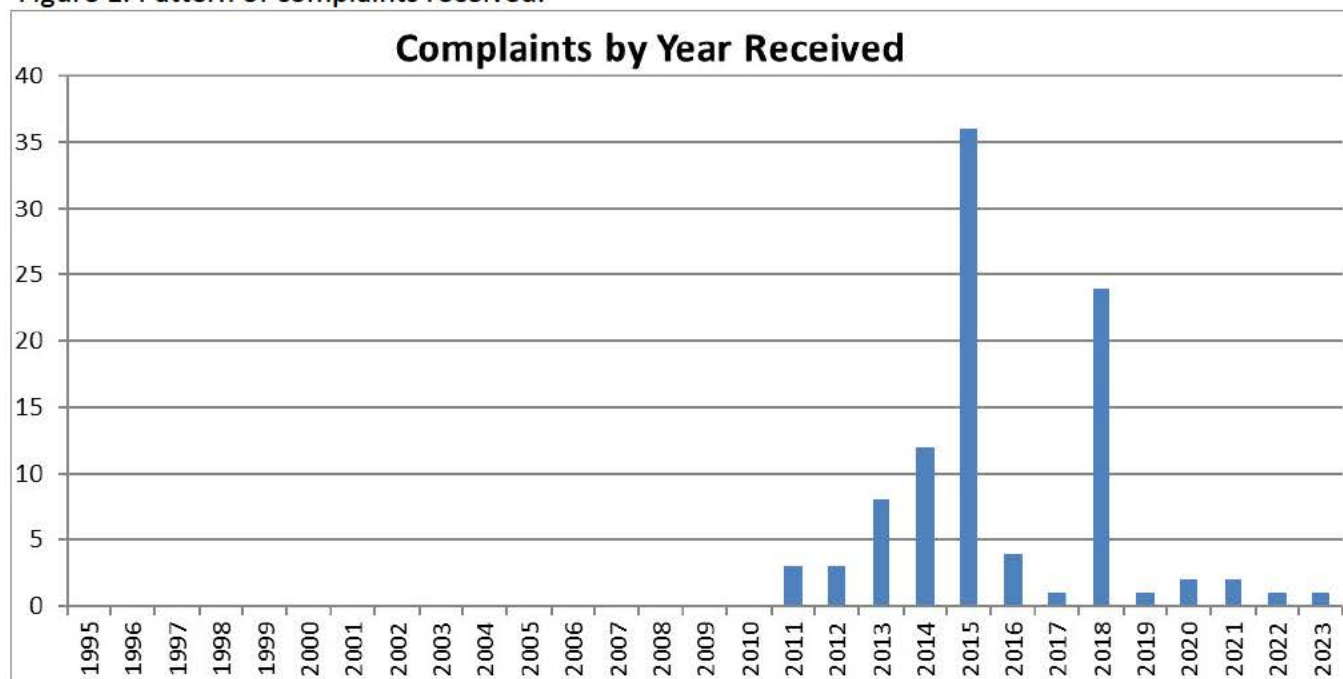
	Number
Total Complaints	98
Number logged on Datix system and closed	93
Number of complaints not on Datix (therefore we do not have a date these were closed)	5
Number who have had a review of their clinical care documented	62
Mean days taken to close complaint	79
Median days taken to close complaint	49
Fully upheld	11
Partially Upheld	10
Not upheld	4
Consent not Received	1
Enquiry	61
Transferred to another unit	6
Full apology regarding their surgery/ care	24
Acknowledgement and apology for their experience	53
Scottish Public Service Ombudsman involved	1
Scottish Public Service Ombudsman upheld	0
Scottish Public Service Ombudsman not upheld	1

The review looked at when these complaints were received by NHS Tayside to try to ascertain whether there were alerts which should have been picked up through the Complaints monitoring processes of the time.

The review identified that the bulk of complaints were received **after** Professor Eljamel was suspended in December 2013. From the data NHS Tayside holds from before his suspension,

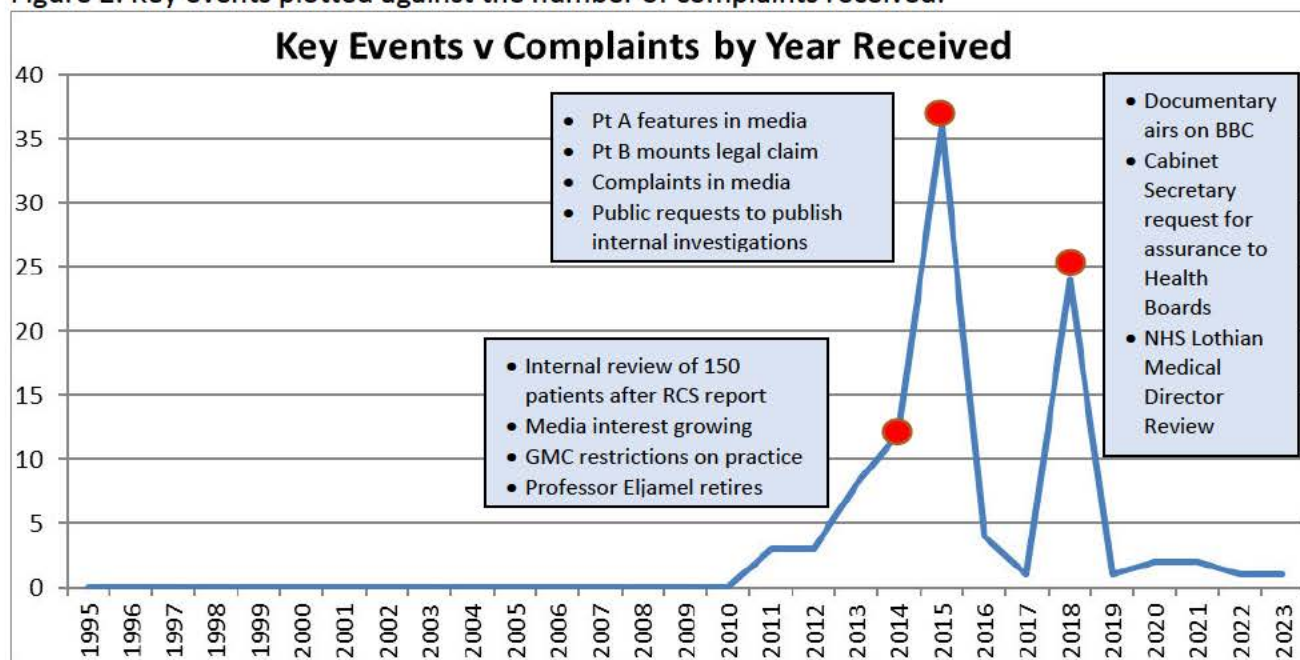
we can see that there were 3 complaints received in 2011 and 3 complaints in 2012. In 2013, before Professor Eljamel was suspended the number of complaints rises to 8.

Figure 1. Pattern of complaints received.



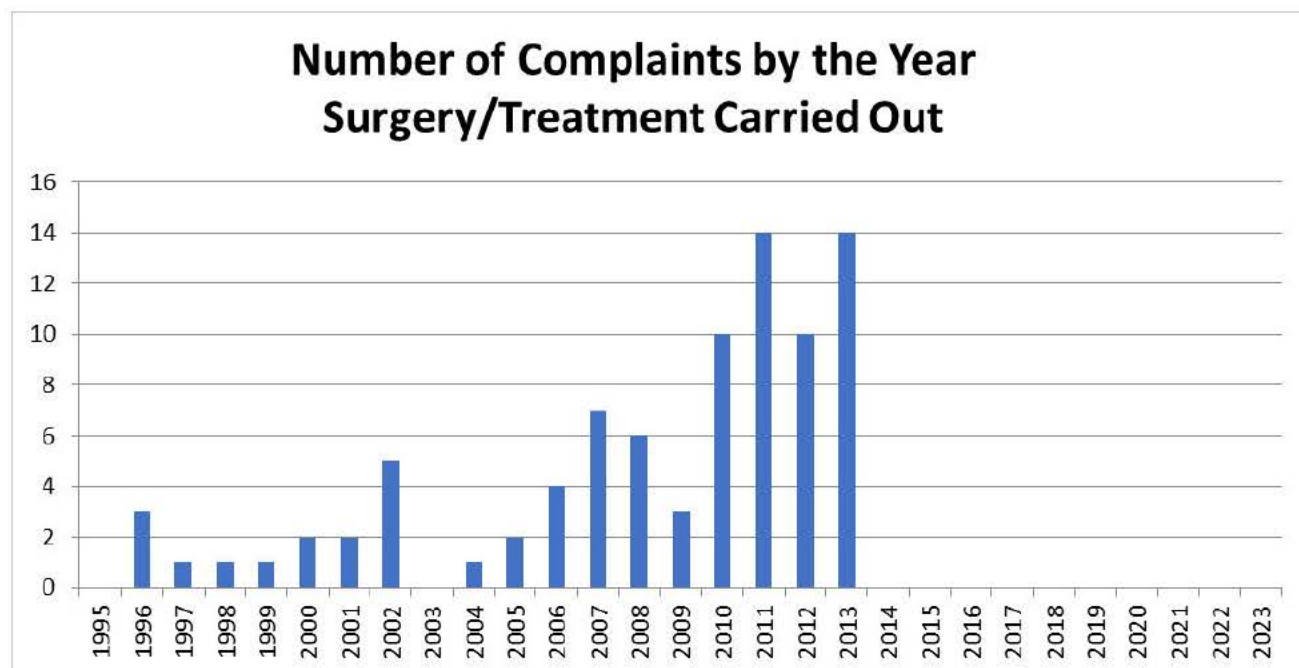
The review then looked at the pattern of when complaints were received to correlate the spikes in the number of complaints being received with related events, including publication of external reports and media coverage, principally in 2014, 2015 and 2018.

Figure 2. Key events plotted against the number of complaints received.



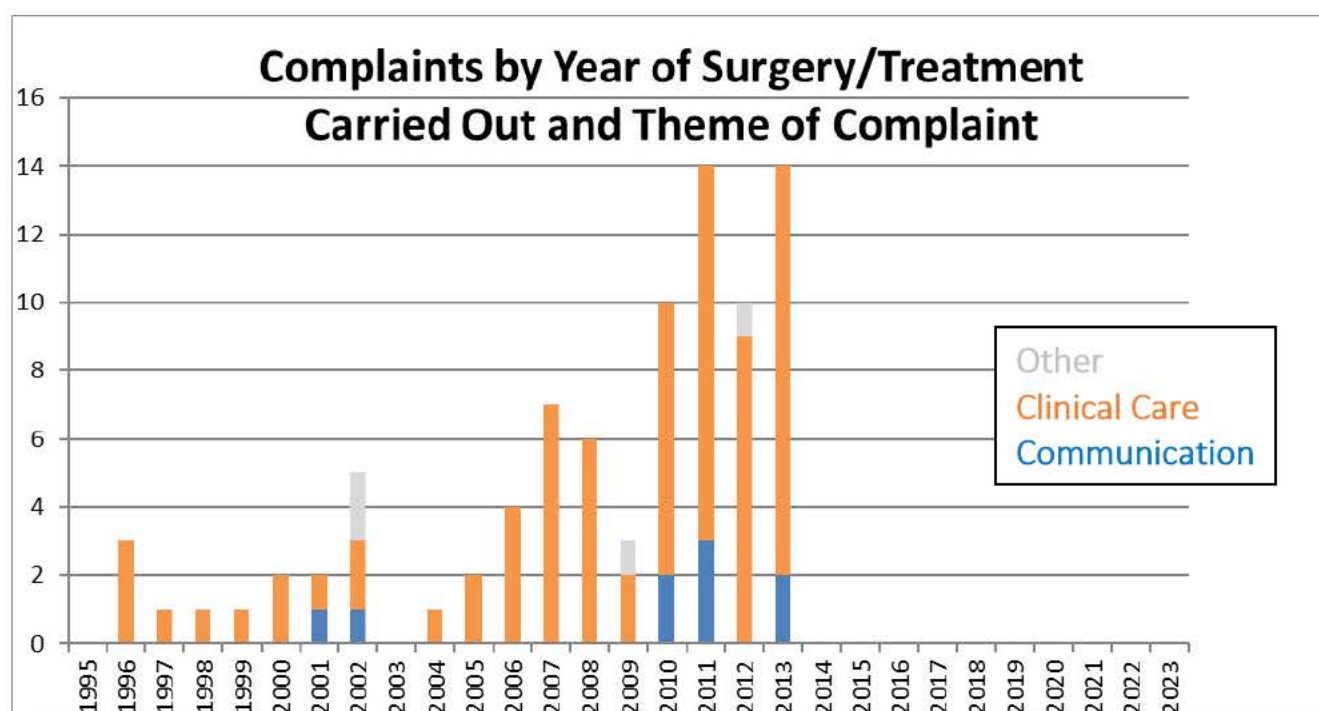
However, when the review looked at all the complaints to see when the episodes of care and/or surgery actually happened, the majority of patients had submitted complaints retrospectively relating to their care, dating back to 1996 onwards.

Figure 3. Number of Complaints by the Year Surgery/Treatment Carried Out



The Review then went on to look at the reasons that patients complained and identified that most of the complaints related to concern over clinical treatment.

Figure 4. Number of Complaints by Year of Surgery/Treatment Carried Out and Theme of Complaint



was no evidence of the tumour in the specimen removed, however prior to this they had been informed by Professor Eljamel that he had partially removed the tumour. It would appear from the information available that he was not open and honest with patient B. On 09/12/2013 the patient underwent successful surgery to remove the tumour by Professor Eljamel. Both surgeries took place whilst Professor Eljamel was under supervised practice. A meeting between patient B and the General Manager and the Clinical Lead was held on 13th March 2014, where the patient expressed their wish not to complain formally. The General Manager advised a note of the meeting would be kept on record in the Complaints and Feedback Department. An apology was sent on 22nd April 2014 via the complaints team that was probably a result of this meeting. Patient B formally complained on 24th April 2014 and initiated a legal claim on 4th February 2015 which was settled in 2016-2017. There is no record of a formal incident being lodged or investigated in this case in line with the adverse events policy.

Therefore, following an examination of the detail of these patient journeys and, with lessons from previous inquiries in mind, the review has highlighted variable processes, poor documentation of investigations, inconsistent responses and missed opportunities to triangulate signals, detect poor practice and act to prevent future occurrences.

4. The Effectiveness of NHS Tayside in Recognising and Reacting to Internal Signals of Concern

Why are we looking at this?

As identified in the previous section, there were a number of signals emerging in NHS Tayside in 2013 to suggest there may be issues with Professor Eljamel and his communications and practice. These were emanating from complaints and clinical governance processes and were the reason that the Royal College of Surgeons review was commissioned in June 2013. The due diligence review can demonstrate there were monitoring systems in place but we need to look at how these were linked up to ensure there could be a triangulation of signals and actions taken to respond to emerging concerns from the multiple available sources. The previous section describes the volume of signals within the system in the period before Professor Eljamel was suspended. In this section we consider the reaction to these signals.

What the due diligence review found:

Overview of response times to complaints and adverse incidents

It was a complaint in December 2012 relating to clinical practice that triggered the first Significant Clinical Event Analysis (SCEA) related to patient C. This SCEA reported on 23 May 2013 and its outcome raised concerns relating to Professor Eljamel's practice which started the series of meetings and events, ultimately triggering the Board Medical Director to commission a Royal College of Surgeon's review.

The complaint was received in December 2012, the SCEA commenced in February 2013 and it reported in late May 2013.