NHS England North East and Yorkshire

Specialised Commissioning Quality Team – Quality Peer Review Report

Trust Name: Newcastle upon Tyne Hospitals NHS Foundation Trust	**Date of Review:** 14 and 15 November 2023
Service: Cardiac Surgery and Transplant	**Type of review:** External Review

Self-Declaration Compliance	29/32	**Peer Review Compliance**	16/32

Methodology:

The quality peer review was commissioned as part of the overarching approach to supporting The Newcastle upon Tyne Hospitals NHS Foundation Trust on their quality improvement journey.

It is acknowledged there has been a series of quality visits to the Trust and the cardiothoracic department, however, the specialised commissioning quality peer review differs from those previously carried out by the Royal College of Surgeons in July 2021 and the CQC visit in June 2023.

The quality peer review aimed to determine the current functioning of the cardiothoracic and transplant service using a combination of an analysis of relevant qualitative and quantitative data, a review of documentation and a service visit across two days. This involved speaking to medical, ward and theatre staff within three separate focus groups as well as a multidisciplinary team (MDT) group meeting. This process provided an opportunity for staff working within the service to provide feedback on what was working well, as well as highlighting any issues or challenges that they believed required further attention. The focus groups and group meeting were well attended by all disciplines. The comment sections of the quality peer review report reflect the outcomes of the focus groups and group meeting.

A self-declaration document was produced containing quality indicators drafted from the cardiac surgery service specification as well as the outcomes of the Royal College of Surgeons report dated July 2021.

Specialised commissioners wish to build on recent improvements, but also to identify where support could be given to the Trust to make further progress with service improvement and development.

Service Overview:
The Newcastle upon Tyne Hospitals NHS Foundation Trust (NuTH) is one of the largest teaching hospital trusts in the UK providing acute, specialist and community services to a large geographical area and diverse population across the North East of England and beyond. The cardiothoracic directorate provides adult and paediatric tertiary services, including heart and lung transplantation, across two main hospital sites: The Freeman Hospital (FH) and Royal Victoria Infirmary (RVI). The cardiothoracic centre based at the FH is one of the country's major heart and lung surgical units and is the only centre in the UK that provides both adult and paediatric congenital heart and lung surgery, heart and lung transplantation and mechanical circulatory support.

Quality Indicator	**Description**	**SD Compliance**	**PR Compliance**
	Governance meetings	**Y**	**N**
Description	There should be a multi-disciplinary clinical governance process in place to monitor the quality of care The service is to learn from and improve performance related to never events, serious incidents, safety thermometer and critical care bundles and benchmark and review all in quality surveillance meetings The team should annually review their data, discuss the progress of their audit or discuss the completed results		
Comments	A new cardiothoracic clinical governance board structure has been established. Three new clinical director posts covering surgery, critical care and anaesthesia, respiratory and cardiology, and paediatrics and congenital have been established and are responsible for leadership of the directorates and to support the delivery of patient care. The reviewers were informed that the application rate for these posts was low, with only one applicant for each position, and therefore no interviews were held. The reviewers recommend even if there is only a single applicant, an interview process to discuss the requirements of the role and the candidates' suitability should still be carried out. These posts are for a fixed term of three years with an allocation of two programmed activities (PAs) per week. It was reported during the group meeting that these clinical director roles required further protected time within job plans.		

	The general feedback whilst speaking to members of the service across the focus groups and group meeting, is that this new structure has introduced further distance between the team and the executive board creating added disconnect between managers and staff. There is a lack of visibility of senior management teams, including executives, within the service. It was reported during the group meeting, however, that within cardiology, the new structure has brought a very proactive approach to working practice and there is confidence in the new clinical director for respiratory and cardiology to drive forwarded positive change. A patient safety and governance lead has recently been appointed who will oversee all clinical governance and patient safety concerns. The clinical governance board has agreed that there was currently no need for a surgical head of department due to the clinical director for surgery, critical care and anaesthesia being a consultant surgeon and able to deal with any issues within surgery. An overarching governance framework is in place; however, team members reported during the focus groups and group meeting, that governance in general was ineffective with concerns around clinical governance being raised, in that processes were not transparent, and communication was poor. While there was paper evidence of governance structures, processes and systems, it became clear that this was an area where there was questionable commitment to the application of some of the key principles of governance, particularly in relation to risk management and decision making. Monthly departmental governance meetings take place across both hospital sites, however, it was expressed during the group meeting that feedback from these meetings was not disseminated throughout the team. Monthly surgical audit meetings take place, with minutes and presentations covering the previous three months being provided. The reviewers, however, do not believe that the example minutes reviewed provide the necessary assurance that robust governance processes are in place. Furthermore, the team reported within the focus groups and group meeting, that due to the levels of clinical activity and the lack of protected time for these supporting professional activities, that they are unable to attend these audit meetings. The board presents patient safety data and the annual audit report at the Trust's patient safety group. Board members also attend the Trust's monthly clinical risk group. Mechanisms for learning are not embedded, as while an e-bulletin is circulated, there is not the time or clear corporate priority to read and learn. The reviewers heard accounts of ongoing adverse and unprofessional behaviours (including allegations of bullying, coercion, harassment, and exclusive work relationships). The reviewers were unable to validate each one of these

	accounts, nor did they have the remit or resource to assess the extent of these behaviours. The reviewers were reassured that the management team and Trust did indeed have action plans in place on culture within the service, however, remained concerned about the impact of these on both staff wellbeing and patient safety. During the focus groups and the group meeting, staff expressed that they were not listened to by members of higher management. There is a lack of confidence from members of staff in the freedom to speak up guardian process. Furthermore, the freedom to speak up guardians' line management was believed to impact on the success and trust of the process. This also is making a significant impact on the health and wellbeing of staff.		
	Patient information	**Y**	**N**
Description	Every patient and family / carer must receive information about their condition in an appropriate format. Verbal and written information should be provided in a way that is clearly understood by patients and free from jargon		
Comments	Several written patient information documents were provided prior to the review. The October 2022 Accessible Information Standard Policy sets out expected standards for patient information. It states that the Trust is committed to ensuring that everyone with a disability, impairment or sensory loss receives the support and information they need to communicate with healthcare staff and to access health services, however, there would appear to be a need for information suitable for those with learning disabilities. A one-page sheet, the Cardiothoracic Pre-Assessment Clinic Information, has been developed which is clear, and detailed and would be helpful to any patient attending clinics. In addition, an information sheet for patients undergoing heart surgery has been developed which covers in detail, information relating to several of the interventions provided by the cardiothoracic team. This is believed to be well written, understandable and pitched at an appropriate level. Further examples of patient information relating to cardiac surgery and percutaneous coronary interventions (PCI) were provided at the visit, which were of high quality in design, and in line with the Policy and national guidance on patient information. These are very recent documents developed by the cardiac rehabilitation team, and it was uncertain how and when they were being used and disseminated to patients/carers/relatives. The team should consider a detailed reference		

	to coping with psychological and mental health elements of recovering from such a traumatic intervention in future editions/reviews. The Trust has a Sharing Letters with Patients Policy produced in June 2023, which aims to ensure that patients/carers/relatives have access to all appropriate information that is being shared with their GP/health care providers, however, attention should be made to the language being more patient friendly and not as clinical. The reviewers commend the web-based heart and lung transplant patient resource, developed by the transplant coordinators in conjunction with Northumbria University and in collaboration with patients/carers/relatives. This resource is well written, broken into easily understandable sections, explains the process and what to expect on the heart and lung transplant journey. The team would benefit from a similar resource being rolled out across other areas in this format to ensure patients are informed and in a good position to understand what they will be facing, helping them to be part of an informed decision-making process. No examples of changes resulting from information gleaned from patient feedback were identified, nor was it clear what improvements had been made in relation to staff information collection initiatives. Friends and family feedback does not appear to be discussed during governance meetings or acted upon.		
	Experience of care	**Y**	**N**
Description	The organisation/service has a robust programme to ensure it listens to patient's experience of care and to the views of the staff, to improve the delivery of a safe, effective, caring and responsive service		
Comments	The reviewers carried out a walkthrough of the clinical pathway focussing on the intensive therapy unit (ITU), theatres, the ward areas and outpatient departments. The care seen mainly was of a high standard and the commitment and compassion of the staff to deliver excellent care was evident across all areas. It was noted, however, on one ward (ward 30) observations were overdue, some by up to over four hours. These extensive delays could seriously compromise the quality of patient care, not least because these inputs are needed for determining early warning scores and allow timely intervention prior to clinical deterioration. At this moment in time, the ward sister was immediately adjacent to the whiteboard showing these delays and it was reported by the single-handed healthcare support worker (HCSW) carrying out the observations, that once completed the observation board would automatically		

	update. The reviewers were not able to identify whether the HCSW was able to ask for support with the delayed observations. There was little space available for both doctors and nurses to complete paperwork and tasks, with the ward sister on one ward using a computer in the middle of the corridor. There was the potential that they could be disturbed when trying to complete documentation resulting in risk or potential error. Junior medical staff also reported that they did not feel there was enough dedicated space to allow them to complete documentation without disturbance and there were inadequate numbers of workstations available to allow them to complete their documentation in a timely manner. It was noted on ward 30, that there were five cubicles located towards the end of the ward, around a corner and isolated from the main ward. The patients within these cubicles are cared for by the staff who are also allocated to bay three and bay four. Bay three and bay four are close by to the cubicles, however, the reviewers were concerned due to the lack of visibility. The visit to ITU showed a well-led, open, calm and focused care environment, with an appropriately high level of staffing and well managed delivery of care. The reviewers were informed that extracorporeal membrane oxygenation (ECMO) patients had two Band 5 nurses caring for each patient, one for the ECMO circuit and one for the patient. The reviewers believe this to be an inefficient use of resources. The ECMO circuit needs little attention taking a gas every eight hours, adjusting gas and flow as needed, and help rolling the patient. The team should consider employing extra perfusion cover or ECMO specialist nurses who can float the unit, looking after a number of ECMO patients, which would be more productive. The reviewers were advised that at times there are two to three ECMO patients on the unit and that currently takes away more nurses, lowering the number of beds available due to staffing shortages. The outpatient department was quiet and had a good anaesthetic presence in the rooms. The transplant unit was clean, modern and well-kept with all patient observations, bar one patient, shown as having been undertaken in the correct timeframe. One patient described exemplary care from the nursing staff and medical staff. It was reported during the group meeting that the staff survey was not completed by many staff as they believed that the results were not acted upon, and the process was a tick box exercise only.

	The reviewers had opportunity to chat with a few patients throughout the walkthrough, and patients visited were happy with their care, with one describing their care as exemplary. Caring interactions were noted between staff and patients on wards. On speaking to the team during the group meeting, it was reported that they were aware an external agency had been brought in to access culture within the service, however, at the time of the review visit, none of the staff spoken to had been given the opportunity to provide any input or insight.		
	Cardiac lead clinician	**Y**	**N**
Description	There is a named lead clinician for the adult cardiac surgery service. The lead should have an agreed list of responsibilities, time specified in their job plan for the role and receive ongoing leadership training		
Comments	There is a named lead clinician for the adult cardiac surgery service who has also recently been appointed clinical director for surgery and anaesthesia. Both roles have an agreed list of responsibilities. The reviewers were informed that the clinical leaders receive two PAs a week to carry out clinical director responsibilities. With the complexity of the challenges faced by the organisation, it may be of benefit to initially increase the number of PA's available for clinical leadership as it appeared that they were stretched in terms of their capacity. Consideration should also be given to provide developmental support to reflect on how they might approach challenges in a novel manner. Appropriate job planning is required with individuals giving up some clinical time to allow them to have appropriate working time for the additional non-clinical responsibilities that these roles carry. The reviewers do not believe it is enough to simply to pay additional money if there is no time in the week to do what is necessary administratively.		

	Cardiothoracic transplant lead clinician	**Y**	**N**
Description	There is a named lead clinician for the adult heart transplant service. The lead should have an agreed list of responsibilities, time specified in their job plan for the role and receive ongoing leadership training		
Comments	There is a named lead clinician for the adult heart transplant service and a lead clinician for lung transplant service and together share the role of director of transplant. One of the two joint directors of transplant receives 0.5 PAs in their job plan since appointment. The other joint director of transplant is yet to have job planning to ensure this is protected time, however, the department is currently undergoing a job planning round at present to ensure that lead roles have appropriate time dedicated in job plans. It appeared to the reviewers that they had a difficult task ahead dealing with some of the challenges between inter-speciality, intra-specialty and multidisciplinary staff.		
	Cardiac MDT core membership	**Y**	**N**
Description	MDTs are a key part of the patient pathway for myocardial revascularisation, aortic valve disease, mitral and tricuspid valve disease and endocarditis and function as a single, disease specific treatment decision making group. There should also be an MDT for pathology of the aorta with vascular surgery and radiology. These cardiac MDTs should include the following core members (depending on the specific sub-speciality MDT) (See self-declaration)		
Comments	The reviewers were informed that there has been a full complement of surgeons for the last two years, however, until recently, they have had no job plans. It was declared by a clinician, that even if job plans had been agreed, it did not mean they always followed clinical practice in relation to responsibilities and accountabilities. It appeared that some clinicians deviated from the recommended consensus of the MDT or failed to bring cases for formal discussion, which was of concern.		

	During the visit, the team described a lack of team working which is problematic and impacting on the service.		
	Cardiothoracic transplant MDT core membership	**Y**	**Y**
Description	The cardiothoracic transplant MDT should include the following core members (see self-declaration)		
Comments	The transplant MDTs are held on a weekly basis with between two and three consultant surgeons in attendance each week. The transplant coordinator uploads MDT discussion onto the patient electronic system at the time of the MDT.		
	MDT meeting (for all Cardiac MDTs)	**N**	**N**
Description	The attendance at each scheduled MDT meeting should constitute a quorum, for 95% or more, of the meetings The MDT meeting should allow and encourage the ability to challenge and provide learning opportunities for all disciplines Attendance at all Cardiac MDT meetings should be formally recorded All MDT discussions must be documented, and the decisions made recorded and subject to regular audit		
Comments	There are four cardiac MDT meetings scheduled: aortic, valve, aortic root ascending and arch and revascularisation. The aortic MDTs are generally well attended, however, the revascularisation MDT is not due to the lack of attendance by consultant cardiac surgeons, who attend infrequently due to lack of staffing. The rationale given for non-attendance at MDT meetings was the lack of patients to present. The established pattern of high-volume PCI through the cardiology service, instead of operative revascularisation for complex patients, means that surgeons do not do as many coronary artery bypass grafting (CABG) operations therefore, they do not attend MDT meetings. Instead, informal discussions are taking place between surgeons and cardiologists regarding specific patients and the reviewers are concerned that these		

	are not documented and only have one viewpoint. There should always be a consultant cardiac surgeon present at MDT meetings. The reviewers were informed that the cardiology MDT functioned well, however, rarely did the cardiac surgeons attend to present cases or offer an opinion as to whether a surgical approach would be preferable or offer advantage over an interventional cardiological technique. The team stated within the group meeting, that surgeons attend regional MDTs, for example, the Carlisle MDT. However, they also reported that outcomes decided at these regional MDTs are not always followed through. One example of this was a patient discussed at an MDT with an outcome for aortic valve replacement and CABG, ended up having a PCI instead with the valve being left alone. This resulted from a late change in the available surgeon for the procedure as a result of illness. Such last-minute decision making outside the confines of an MDT poses potential risk for patients. This is also apparently the same for PCI patients with changes being made intra-procedurally. During the first day of the visit, a clinical event was reported to the reviewers. A patient scheduled for an operation was taken to the theatre reception/recovery area for surgery, however, due to unplanned leave, the case was covered by an alternative consultant surgeon. On presentation of the patient, the treatment strategy was altered, and a different procedure was undertaken, contrary to the documented MDT decision. The reviewers were significantly concerned this change in clinical management strategy so close to a planned procedure could both expose the patient to additional risk and impact on clinical outcomes. Furthermore, it was unclear how the patient was engaged in this change in plans, and what informed consent was involved. The reviewers were informed within the focus groups, that such an event would occur almost weekly and described regular occurrences whereby unstable patients listed for theatre for CABG are then taken to the catheterisation laboratory (cath lab) for PCI. During the high-level feedback session on day two of the visit, it was acknowledged that this had not yet been placed on Datix, however, it would be recorded. It was not identified when or by whom patient discussions were uploaded onto the patient electronic system.

	Prioritisation meetings (in-house patients and inter-hospital transfers)	Y	N
Description	Each surgical centre should convene a daily MDT meeting for consideration and prioritisation of urgent inpatient referrals involving, as a minimum, the on-call cardiologist and cardiac surgeon		
Comments	The daily theatre meeting is held at 8am bringing together all surgeons using theatres to discuss priorities and overnight emergencies/transplants/developments to determine what resources are available that day. Nurse led daily bed meetings take place at 9:15am, with attendance from each ward/theatre/ITU lead, for consideration and prioritisation of urgent inpatient referrals. At each meeting pending unstable patients are discussed to highlight patients that are ready for surgery and patients awaiting transfer. Patients get prioritised by the number of beds on the day. The reviewers were informed that prioritisation meetings are not attended by the week on the ward consultant surgeon, therefore, nursing staff are having to make clinical decisions regarding surgical patients. Unstable patient prioritisation and management is part of the responsibility of the week on ward consultant. It was highlighted that nursing staff were frequently called to review electrocardiograms (ECGs) by the emergency department and ambulance teams. There is limited support from the medical teams for the nursing staff deciding which patients get an ITU bed, which cardiac surgery patient should be prioritised for theatre and also in managing cancellations. Nursing staff reported times they are on their own to cover ward beds and make decisions above their competence and expertise. The reviewers were informed that the nursing staff were worried for their professional registration as a result and do not feel it appropriate to be asked to review deteriorating patients when medical staff are unavailable. This is unsafe and nursing staff should not be making decisions as to listing patients for theatre or cath labs. Prioritisation of patients going to theatre was unclear. The reviewers were concerned around the timings of these meetings, and these should be reviewed. Theatre time does not seem to be appropriately utilised. If theatre discussions are taking place prior to prioritisation meetings, then this means patients requiring emergency surgery may not be listed, with elective patients taking priority. Theatre staff reported uncertainty about the application of prioritisation processes and the limitations of the post operative recovery provision.		

	The lack of a consistent approach to the management of patients waiting for in house urgent surgery is unacceptable. This is causing emergency patients to face significant delays for procedures. This could seriously compromise the quality of clinical outcomes. In-house CABG waiting lists are over two weeks for an operation as ITU beds are taken by transplant patients or those needing ECMO. The Trust has a lot of acute coronary syndrome (ACS) referrals (38 at the time of the visit) with an average of about six days waiting time for these patients to be transferred into the Newcastle hospital system for diagnosis/treatment from outlying hospitals. It was reported during the group meeting that one consultant completed 15 Datix's last week regarding transfer time for ACS patients. The number of patients with ACS has a significant impact on the bed demands. These patients should be transferred in from the outlying hospitals for diagnostic/therapeutic procedures. The system does not appear to be responsive to the varying demands therefore patients may end up waiting for long periods (often >2 weeks, and certainly >1 week) to be prioritised for transfer into the hospitals for definitive management. There is potential for the condition of patients to deteriorate during this time. Furthermore, this has an impact on bed occupancy and the general efficiency in the unit. Patients should be being treated and moved onwards towards convalescence, and in instances being repatriated back to referring hospitals.		
	Perfusion service	**Y**	**Y**
Description	There should be a dedicated perfusion service which is fully compliant with Department of Health guidance 'A guide to good practice in clinical perfusion'[1]. Monitoring during surgery needs to be compliant with the Surgical/Anaesthetic recommendations 'Recommendations of standards for monitoring during cardiopulmonary bypass'[2], and that there be near patient testing available to both the theatres and recovery area		
Comments	The perfusion staff reported that they were well supported and have a clear line management and accountability structure in place. A College visit from the Society of Clinical Perfusion Scientists in February 2022, showed a unit who work well together and there were no patient safety concerns identified. Plans were going to be put into place to increase perfusion staffing		

	to accommodate the move of paediatric cardiac services to the RVI. The senior perfusionists have also been regraded to a Band 8b to retain staff, and there is a pathway for main grades on Band 7 to work towards completing competency-based training towards the 8b grading. It was unclear whether there was a revised document that describes the competency framework for the automatic progression to the new Band 8b grading, however, competencies required for eligibility for promotion to Band 8b was provided to the specialised commissioning quality team following the review visit. The N+1 (N = number of theatres and +1 = spare available perfusionist) College of Clinical Perfusion Scientists minimum standard is adhered to for routine and emergency work, and this is supported across the MDT and management team. The perfusion department strictly adhere to European Working Time Directives. Monthly head of department meetings are attended by the chief perfusionist and there is an annual perfusion executive meeting which the chief perfusionist and the college tutor attends. This is a meeting with the assistant medical director, clinical director and director of operations. There are also regular informal perfusion meetings allowing peer support and case discussion. The lead perfusionist attends and contributes to mortality and morbidity (M&M) meetings and attends all clinical governance meetings within areas of work.		
	Cardiac surgical activity and sub-specialisation	**Y**	**Y**
Description	Cardiac surgeons demonstrate the experience, competencies, activity and relevant MDT attendance to treat elective and emergency work in the sub-specialties. Annual workload data by each named surgeon		
Comments	Annual workload data extracted from Dendrite for current surgeons, per surgeon, arranged over three complete years prior to the review, were shared with the reviewers. The data was inclusive of all major cardiac surgeries, emergency cases and any procedures, although very few, that were performed in the private sector. The data does not include non-major surgery i.e., washouts, vac dressing changes, wound debridement's as these are not captured on Dendrite. On review of the data, it was evident that workload was not equitably distributed across the surgical team. It was noted that one surgeon was the responsible consultant for 14 patients last year, being the first operator on four of these patients		

	and first assist in five. The numbers for this surgeon look to be similar for this year also and the reviewers were concerned as to why his operating numbers were so low. Furthermore, staff raised concerns about attribution and supervision of surgical activity. Some cardiac surgical activity is currently being attributed as the work of one of the senior surgeons, whilst senior fellows with over two-years' experience are carrying out procedures independently, and without direct supervision. Whilst being on hand in case of emergency, the named lead consultant is not present. The Trust facilitates annual medical appraisals and five yearly revalidation, and the reviewers were informed that members of staff are able to choose their appraiser for this process. Despite this, however, appropriate job plans have not been in place for consultant surgeons. A number of consultant surgeons are on a minimum of 12 PAs per week. Three more recently appointed surgeons have been on 10 PA contracts as per their agreed job plans, despite providing equivalent hours work and being fully involved in transplantation.		
	High risk patients	**Y**	**Y**
Description	There is a transparent process for high-risk cases and dual consultant operating. Both consultant surgeons are expected to be present for the duration of the case and scrubbed for the majority of the time at the operating table		
Comments	It was evident that dual consultant operating was undertaken appropriately for high-risk patients. Surgeons double scrub for high-risk patients or more complex surgery which is to be commended. Dual consultant cases accounted for 15% of all cardiac surgery cases in 2022/2023.		

	Acceptance to treat	**N**	**N**
Description	Patients needing in-house urgent cardiac surgery to have the procedure within 7 days of acceptance. Team based approach to accepting and scheduling patients with appropriate delegation to sub-specialists, where needed		
Comments	It was reported during the focus groups and group meeting, that cardiac waiting lists are too long and unsafe which is impacting on patient safety. Patients needing in-house urgent cardiac surgery do not always have the procedure within seven days of referral. The Trust reviewed data from April 2023 to August 2023 which showed 156 patients were referred for in-house urgent cardiac surgery, out of which only 49 patients had their procedure within seven days of receipt of their initial referral, which equates to 31%. At the time of the visit, there were 18 patients waiting over two weeks for cardiac surgery. Waiting times for elective cardiac surgery was up to two years as more specialised cases took priority with non-ST segment elevation myocardial infarction (NSTEMI) patients waiting up to 12 months with angina. The reviewers were informed that there are currently 50 P2 transcatheter aortic valve implantation procedure (TAVI) patients waiting procedures. The reviewers were informed that transplant patients take priority, and if there are ECMO patients in ITU, then this can impact on staff available to care for post-operative cardiac surgery patients. Capacity has also been affected by telemetry availability and theatre staffing. Furthermore, it was reported during the group meeting and walkthrough, that elective patients are listed before in-house urgent cases as it is more challenging to cancel an elective patient than an in-house patient, if required. The theatre schedule template puts unstable patients first on the theatre list, however, they are not always prioritised. Anaesthetists are prioritising patients on the theatre list which is then leading to discussions on the day of operation and potentially contributing to treatment strategies being altered due to the lack of a cohesive MDT discussion. The week on the ward protocol has recently been developed which should provide dedicated surgeon oversight to new referrals and prioritisation of unstable patients in the system. The protocol states that each surgeon will fulfil this role on a one in eight basis. The reviewers were informed that this process is not always successful on effectiveness and is dependent on clinical activity as to whether the surgeons can take one week out to look after the wards and the unstable		

	system. The protocol states that during the week on the ward, the consultant may choose to do no scheduled operating, however, it was reported during the focus groups and group meeting, that there is no way in which to cancel commitments or arrangements put in place to cover theatre. Therefore, the week on the ward rota is not fulfilled nor fully implemented and is impacting on the nursing staff. Due to the lack of junior doctors, and clinical activity of the surgeons on the rota, this has led to clinical decisions, for example about relative priority of patients for transfer, being taken in isolation by nurse practitioners. Nursing staff taking on this responsibility, without senior medical oversight, could expose them to unreasonable professional risk and could seriously compromise the quality of patient care. The nursing team reported that they believed the care they provided was under par due to a lack of support from the consultant week on the ward process and the ability to escalate concerns. It was evident the nursing staff work hard to try and maintain a safe environment and provide organised care during difficult situations. In-house cardiology patients also waited longer than was appropriate for transfer into the centre for PCI.		
	Theatre and wards	**Y**	**Y**
Description	All open-heart surgery is undertaken in fully equipped and staffed operating theatres and that patients who have undergone such surgery are returned to an area capable of managing such patients, including those who do not follow a straightforward pathway and might necessitate prolonged ventilation and inotropic support, an intra-aortic balloon pump, haemofiltration and access to many additional specialists who should be available to attend at short notice. This should be available on-site. There needs to be fully trained staff, medical and nursing, dedicated to such patients.		
Comments	There are two adult cardiac theatres, one paediatric theatre and one to two thoracic theatres with weekend theatres lists staffed for emergencies only. Staff reported during the focus groups, concerns that there was a lack of professionalism between surgeons and nursing leadership in the theatre environment. Nursing staff were often spoken to by surgeons in an inappropriate manner and vice versa. Nursing staff in theatre stated that they often had to act as the peacemaker between surgical staff in prioritising which cases were seen to be an emergency at weekends, with surgeons often all stating that their case was the priority.		

	The reviewers were informed that exclusive work relationships were often too close to be objective and this was reported as resulting in cliques and favouritism within the workplace. Staff reported during the focus groups, that very few surgeons were engaged with the World Health Organisation (WHO) surgical safety checklist as a safety tool and treated this as a tick box exercise. The Trust would benefit from review of the checklist to ensure that it is suitable or whether any adaptations are required to ensure successful implementation. It was evident staffing groups are proud to work at NuTH within a specialised service with such diversity, however, management of the service is difficult as the infrastructure remains the same. A lack of space and quality of space is believed to be impacting on the quality of the service. During the group meeting, the team reported expansions within other directorates within the Trust and no one championing or advocating for the cardiothoracic service. Staff did not feel that the executive management team beyond the directorate showed any interest in their service. The team feel isolated in relation to the business case process and are unaware if there is any oversight individual within the Trust for business case production to provide support. The reviewers heard accounts of changes to treatment plans being carried out without patient consent. Staff within the focus groups, reported concerns about the timing and recording of consent in relation to procedures being undertaken, as well as questioning the fidelity of recording. This is a safeguarding concern. Theatre staff are working over and above their job plan on a goodwill basis, however, this is often taken advantage of with unprofessional behaviours and extreme emotional pressures being used to secure this goodwill. New telemetry has been installed across the wards and a new thoracic high dependency unit (HDU) had been created which would aid the throughput for lung cancer patients. In 2021 additional nursing investment was made to theatres across scrub and anaesthetic teams to support additional thoracic cancer work in line with the lung cancer health checks programme. In addition, the trust has secured additional agency nurses to help keep theatre space open, which has struggled to be maintained in recent years due to sickness levels. There has been no additional theatre sessions without appropriate funded nursing support, however, gaps in nursing due to historic vacancies/ absence/supernummery has resulted in difficulties covering all sessions. Currently, there are one WTE registered nurse and two WTE unqualified theatre staff vacancies. Theatre staff reported that they were always on standby in case of an emergency transplant patients.

	Insufficient cath lab capacity was reported during the group meeting. It was noted that a third cath lab is due to open in January 2024 and this was described as a return to pre-Covid capacity, however, specialist services had since increased (TAVI/MitraClip) and demand has grown since that time. There is no cath lab day case unit, therefore patients are being admitted to a bay within ward 27, cardiology, which is dedicated for day case and holds eight day case chairs, however, has restrictions of single sex use. This bay closes each night and reopens each weekday morning to accommodate day case admissions. Portfolios of core competencies were provided for anaesthetic assistants, recovery practitioners and theatre practitioners as well as the intra-operative competency pack, all of which were very detailed and thorough.		
	Cardiothoracic transplant workload	**Y**	**Y**
Description	The cardiothoracic transplant centre should carry out 25 or more heart transplants per year. Annual workload data by each named surgeon		
Comments	There has been an increase in the number of heart transplants performed in the UK last year (215 transplants) with NuTH carrying out a total of 41 (28 adult, 13 paediatric), which is similar to two other centres. The NuTH covers a wide geographical area, and they have the highest number of patients on the adult active transplant list, as well as having a paediatric transplant list. The transplant coordinators appeared cohesive, however, pressured and believed they were unsupported in the role, having to cover 24/7 on-call with reduced members of staff. It was noted that in spring 2021, there was a period where of the six coordinators, two were on sick leave and one had taken a 12-month secondment. Therefore, a timely reasonable replacement was not possible due to the long lead in and training period. It was acknowledged that cover arrangements were not suitable, therefore, an additional seventh WTE transplant coordinator was added to the on-call rota in summer 2021. The reviewers were concerned to hear that staff were unaware of duty of candour taking place and at times staff feel they are not being honest with their patients.		

	Heart transplant decline rate	**Y**	**Y**
Description	It is up to the heart transplant team to discuss any issues there may be with the organ and decide whether to accept or decline an offer of a heart. There is a written protocol in place for decision making and those involved		
Comments	There is a written heart transplant assessment protocol for decision making and regular review meetings take place with a reasonable number of staff in attendance to discuss declines. Documentary evidence was provided regarding decision to decline or transfer of patients to other centres. Over the last three years, NuTH have consistently had a high decline rate for heart offers. They have also had the highest number of offers. The reviewers were informed this was due to changes in transplant staff, therefore activity took a decline, however, figures are starting to increase. Heart transplant data provided showed NuTH survival rates were lower than the national rate, at 30 days and one year during the period 1 April 2018 to 31 March 2022. NHS England Blood and Transfusion (NHSBT) annual report published in August 2023, showed figures of 30 day patient survival rate at 89% compared to 92.1% nationally, and one year survival rates being 81.5% compared to 85.9% nationally. The quoted lower survival rates are not statistically significant and have not been flagged as an outlier by NHSBT.		
	Interdependency services	**Y**	**Y**
Description	All cardiac surgical units must have detailed and robust working relationships with all other major branches of acute medicine and surgery (see self-declaration)		
Comments	Reporting of good working relationships with interdependent services was provided. Issues were highlighted regarding dual wards at the FH and RVI. The service lost a ward, equating to 11 beds, due to COVID which has now stayed as a respiratory ward following the pandemic, causing a shortage of beds across the directorate. Conflict over beds was described, with different services competing for beds.		

	The echo service looks to have insufficient capacity as many patients are discharged without post operative echo for assessment of left ventricle function, which could impact on a patients decision to resume driving/DVLA requirement.		
	24/7 cardiac surgical on-call provision	**Y**	**N**
Description	The cardiac service should have 24/7 emergency on-call rota in place whereby a consultant cardiac surgeon is available to perform surgery or offer telephone advice. The service should have audited this provision to ensure that this is the case		
Comments	Copies of the on-call rota for May to August 2023 were provided, however, it was noted that inclusion on the rota was not equitable across the surgical staff. Consultant surgeons cover cardiac, thoracic and trauma, transplant and ventricular assist devices (VAD)/ Mechanical circulatory support (MCS) with occasions when the same consultant will cover both cardiac and transplant on the same day. The reviewers were concerned as it was unclear what would happen if there were a transplant and a cardiac case requiring cover at the same time. The team would benefit from a combined rota for transplant/VAD in line with other units in the UK. The service has not audited the 24/7 on-call rota process.		
	24/7 cardiac device on-call provision	**Y**	**N**
Description	The cardiac service should have 24/7 emergency on-call rota in place whereby a consultant cardiologist is available for device related emergencies. The service should have audited this provision to ensure that this is the case		
Comments	Copies of the on-call rota for May to August 2023 were provided. There are two consultants that cover the VAD/MCS related emergencies on-call rota. While call outs are low, the surgeons must plan their work/life balance accordingly to being on call.		

	The level of on call was noted to be very high, with one consultant covering 20 days in a month. This is not an acceptable or a safe on-call rota. This process is not sustainable and could significantly impact the health and wellbeing of the individuals. The reviewers were informed that a retrieval surgeon will attend to carry out procedures rather than the on-call surgeon.		
	24/7 transplant surgical on-call provision	**Y**	**N**
Description	The MDT should provide a 24/7 on-call rota of consultant core surgical members whereby at least one is available for patient assessment and intervention		
Comments	Copies of the on-call rota for May to August 2023 were provided, however, it was noted that inclusion on the rota was not equitable across the surgical staff. The transplant surgical on-call provision appears to be under pressure with ongoing need for clinical supervision of junior consultant staff, which has resulted in senior surgeons covering the rota more frequently.		
	Care arrangements	**Y**	**Y**
Description	All patients will have a clear follow-up plan at the time of discharge along with a discharge summary and plan to be given to the patient and the GP		
Comments	All disciplines across all staffing groups are committed to help deliver a high-class service despite organisational and transactional difficulties being reported. Discharge summaries are completed by nurse practitioners on the ward. A request was made prior to the visit to review six sets of patient records for the purpose of understanding how patients progress through treatment and care in the cardiothoracic service. On the day of the review, staff struggled to navigate the electronic patient records and were unable to access certain good documents.		

	Therefore, the reviewers had sight of three sets of patient records, from among those already reviewed at M&M meetings. In two out of the three sets of records, the pathway was difficult to work out and there was no evidence of MDT discussions taking place. In one case, there was a delay of three months between upload of a referral to the response informing the patient that further investigations were required before they could be considered for revascularisation. This delay, which should be in the Trust's control, is excessive and could significantly compromise patient outcomes. It was unclear as to why there was a three-month delay in referral to contact with the patient and no further documentation was recorded during this time. The reviewers were disappointed in the sub optimal case notes evidenced. There are clear deficiencies in the pathway and the service needs to close the loop following the level of discussions at M&M meetings.		
	Clinical guidelines	**Y**	**Y**
Description	There are clinical guidelines in place as per the service specifications		
Comments	There are a number of clinical guidelines, protocols and standard operating procedures used within the clinical board which are stored on the Trust's intranet. Some examples were provided for the visit, which were well written, and evidence based. There was a lack of document version control; however, the reviewers were assured that mechanisms were in place to ensure timely review. The reviewers were informed that the newly appointed patient safety and quality lead will ensure that the mechanisms for guidelines and pathways are being followed. Quality, quality assurance and quality control are high on the remit agenda for this role. It was noted that hard copies of the guidelines and protocols are kept on ITU for ease of access.		

	Patient pathways	**Y**	**N**
Description	There are agreed patient pathways in place. The pathways should include the relevant contact points for the services		
Comments	There are agreed patient pathways in place, however, documentation is limited and there was little evidence that pathways are being followed. A clear pathway was shown by the preassessment service for pre-operative management and anaesthetic review. Timely progression of patients along the appropriate clinical pathways appears to be slow. It was not clear to the reviewers whether this situation was because of inappropriate pathway design, or whether it was brought about by inefficiencies in various steps of the pathway. As a regional ACS centre, it is a challenge to complete admissions and transfers appropriately, with the ACS waiting list consistently above 30, and the inability to admit for treatment due to bed pressures.		
	Rehabilitation pathway	**Y**	**Y**
Description	All patients should be offered cardiac rehabilitation. Phase 1 rehabilitation will be carried out during the inpatient stay. This will be undertaken by the High Dependency Unit (HDU) ward nurse/cardiac rehab nurse. Upon discharge patients should be referred to the local district general hospital or GP, as appropriate, for medical review and to the local cardiac rehabilitation service for cardiac rehabilitation unless this is to take place in the base hospital when a similar referral will be made		
Comments	All patients are offered cardiac rehabilitation with phase one rehabilitation carried out during the inpatient stay. It was noted there is a team of four specialist cardiac rehabilitation specialist nurses who cover all five cardiac inpatient wards across the FH and RVI. Unfortunately, the reviewers did not have the opportunity to meet with this cohort of staff during the walkthrough or at the MDT review meeting.		

	There is no dedicated psychologist linked to the service, however, timely access to the trust-wide service was reported during the walkthrough.		
	Patient outcome data	**Y**	**Y**
Description	The service must submit patient outcome data, in a timely manner (see self-declaration)		
Comments	The Trust submits patient outcome data as requested in a timely manner. Provided within the documentary evidence were copies of the National Cardiac Rhythm Management Report 2023, the Myocardial Ischaemia National Audit Project (MINAP) 2023, the NHS BT annual report on heart transplantation 2023 and the Intensive Care National Audit and Research Centre (ICNARC) 2022-2023. The reviewers were informed about and observed directly, the difficulty in navigating and extracting data from the electronic patient record system. It is unclear how patient's harms are recorded whilst on the waiting list for cardiac surgery. The service would benefit from dedicated data entry clerks to ensure accurate and timely data is recorded and maintained.		
	Specialised Services Quality Dashboard	**N**	**Y**
Description	The service will complete / update the nationally agreed Specialised Service Quality Dashboard for those services which are not pulled from the outcome registry/databases		
Comments	The Trust participate in the collection of specialised services quality dashboard (SSQDs) data. A report is produced by the Trust's information services team which is shared with the clinical governance and risk department. In turn, it is then presented to the clinical outcomes and effectiveness group and escalated to the quality committee and Trust board, if required. An example of the process was provided within the documentary evidence. It was identified, via the SSQD that the percentage of cases where left ventricular ejection fraction (LVEF) was measured prior to discharge was lower than the national average. As a result, discussion took place with the cardiothoracic clinical board. This identified that there were a number of factors contributing to this which included capacity challenges as well as some coding anomalies. At the time,		

	the Trust began outsourcing capacity in addition to the formulation of a business case for the longer term. The risk was also recorded on the clinical board risk register and continues to be reviewed regularly by the leadership team (current rating: 8 (low)).		
	Audit programme	**Y**	**Y**
Description	The cardiac service should participate in the National Adult Cardiac Surgery Audit (NACSA). The team should annually review their data, discuss the progress of their audit or discuss the completed results		
Comments	A copy of the National Adult Cardiac Surgery Audit (NACSA) summary report 2023, which reviews 2019/2020 to 2021/2022 data, was provided. The team should focus on the progress and implementation of the six recommendations listed within the report. Theatre staff indicated that it was difficult to participate in the learning processes from audits, as ring fenced time is limited, therefore, operational demands meant they were unable participate and contribute. This is impacting on staff feeling undervalued. The service would benefit from a robust audit programme, other than those required nationally, to engage staffing groups and allow evaluation of processes and procedures to ensure service improvement is made.		
	Clinical trials	**Y**	**Y**
Description	The MDTs should produce a report at least annually on clinical trials		
Comments	Across 2022/2023 and 2023/2024 the cardiothoracic department had 72 studies with active recruitment, with 1399 participants recruited in total from these trials. A snapshot from clinical trials research recruitment dashboard for 2022/2023 and 2023/2024 was provided, showing the five trials under the cardiothoracic directorate with the highest level of recruitment. These being AtOM-CF Study (Part 1) with 184 patients recruited, Locomotion with 137 patients, Orion-4 with 123 patients, BHF Protect-TAVI with 107 and Prospect with 83 recruited patients.		

	Clinical supervision	**Y**	**N**
Description	Core members of the team with direct clinical contact, should receive a minimum of 1 hours clinical supervision per month		
Comments	Junior doctors described good support and adequate supervision from the respiratory consultants. Nurse practitioners feel supported by the thoracic lead clinician and thoracic surgeons, however, senior cardiology and surgical supervision was limited. The loss of trainee doctors from the surgical training program has resulted in a deterioration in the quality of support being received. Clinical supervision is not provided to individuals on a regular basis. There is no protected time allocated to those individuals with direct clinical contact to receive health and wellbeing supervision.		
	Risks	**Y**	**N**
Description	The number of risks relating to the cardiothoracic services that are currently on the organisation, or directorate, risk register What the risks are and how are they being managed		
Comments	A copy of the cardiothoracic board risk register was provided. It was evident that this document is not used as a dynamic tool to deal with and mitigate risks. The register had a number of significant risks going back approximately 12 years which had not been addressed nor had actions attributed to make improvements. Staff reported during the group meeting, that they did not feel that the register was being used for the purpose for which it was intended. There was no transparent process to inform the staff why the wider organisation had deemed such risks acceptable. Risks to patient safety and clinical work had been highlighted by staff during the visit, however, these had been mainly ignored or no feedback had been received by the teams regarding the process. Staff are unclear who is accountable and how risks are managed.		

	Several staff expressed a lack of confidence in the Datix risk management information system and underlying Trust processes, specifically, outputs of the system are not being made visible to reporters, and there is no reports of feedback or learning being made. Furthermore, the team reported inappropriate amendment of Datix entries. Concerns are raised recurrently, however, these are seen as isolated incidents and there is little done to deal with these in a collective thematic manner. Failings in incident reporting could seriously compromise the quality of clinical care as well as staff health and wellbeing. It was noted, however, that within cardiology a clinical governance co-ordinator manages the Datix entries and works closely with the Datix team. Improvements need to be made surrounding Datix reporting, and supporting those raising concerns as well as feeding back results in a way that people feel valued and not harassed by senior members of the team.		
	Complaints	**Y**	**N**
	Every person that accesses the service is able to raise concerns and complaints about their care and/or treatment		
Comments	There is a Concerns and Complaints Policy in place which applies to all concerns and complaints raised by, or on behalf of, a patient. The Trust does not produce an annual complaints report including themes, trends and learning. Instead, the Trust's complaints panel reports into the Patient Experience and Engagement Group, who provide a quarterly chair's update to the Quality Committee. The last four quarterly reports were provided within the documentary evidence. Trends, themes and local learning from complaints is led by the departmental clinical governance leads in each specialty and shared at the monthly audit meeting, however, staff were unaware of complaints, action plans and improvements.		

	Registered nurses turnover rate	Y	Y
Description	A percentage of Registered Nurses that left an organisation to join another NHS organisation, left the staff group or left NHS over the previous 12 months. A high turnover rate may indicate a number of opportunities to identify reasons for staff leaving and allow management the chance to introduce staff retention schemes to lessen the impact of staff leaving. The turnover rate includes a certain amount of expected turnover for normal transition of staff, including career advancement, promotions and voluntary reasons for leaving. This is also can be affected by region and geographical dependencies		
Comments	Nurse turnover has been high, and during the group meeting, the team reported nurses leaving for less stressful roles in other organisations / specialities, which has led to skill mix issues. During COVID, ward 29 staff supported the respiratory service at the RVI site, including ward 49. Whilst the respiratory ward 29 at the FH remained closed, this led to unrest within the workforce when allocated to different wards. When ward 29 reopened, some staff took the opportunity to remain on ward 49 and others, because the ward had lost some of its respiratory identity and made the choice to take up new posts. It was reported 70% to 80% of skilled respiratory nurses left following COVID and closure of ward 29. There was no evidence of a recruitment and retention plan or health and wellbeing actions. There has been a successful recruitment drive, however, these members of staff are inexperienced and require training, which is putting pressure on staffing resources. The acuity of patients on the wards means that there are more unstable patients, and the nursing staff are finding this harder to manage and sustain. Wards reported at establishment/safe registered staffing levels. It was reported during the focus groups, that the critical care establishment is 21/22 nurses per shift with an increase to over recruit 12 members over establishment, to ensure adequate staffing levels to attend study days, training and education. There are two vacancies on ITU, and on occasion fall short of staffing levels due to unplanned absences. Staffing challenges due to highly complex transplant, VAD and ECMO patients means there is still a shortfall in staff to cover all theatre slots impacting on patients having surgeries cancelled. The reviewers were informed that the chief nurse has oversight of the nursing compliment and there is confidence in this process going forward.		

	During the focus groups, it was reported that staff absence is low in cardiology, and below the Trust average.

Additional Comments
During the focus groups and the MDT review meeting, staff responded openly and with candour. The reviewers acknowledge how difficult this was and commend the team for their honesty throughout and openly sharing their concerns. Amongst the medical team there was a reflection that the service is delivered on a degree of goodwill, and that a lot of extra work was being carried out beyond their specialty. It was reported that the VAD and transplant programmes were working well, and it appeared that many of the good services and service improvements had grown organically, often because of a particular individuals' passions or a keenness to deliver in an innovative way. As a result, there was not an engagement of the team in the development of a business case approach, setting out the evidence, the costs, the resources needed to continue after an initial trial period. This appears to lead to a disconnect between the team delivering services and senior management charged with the planned and strategic delivery of new services and ways of operating. Several staff expressed frustration at not understanding, nor being involved, in business case development. The feeling was that both the medical and the nursing establishment were tight in all areas and there was a lack of junior doctors and fellows within the department. It was believed that it would be difficult to maintain the cardiology tertiary services if there were any instances of long-term unplanned absences. The closing statement from one consultant, was that NuTH was a good place to flourish. It was evident the ward staff were patient focused, with many having years of experience and knowledge within the service. What clearly concerned these staff was the extent to which they received both the patient and the clinicians' frustrations, resulting in tension and stress within the department. Expectations and pressures are very high. Concerns were also raised in relation to the removal of registrar trainees and the gap this has left within the service which is impacting on health and wellbeing. A good training programme was described; however, this means a junior workforce, and it is believed that quality of care has declined. It was reported that they had a supportive peer network, and that between themselves welcomed the sharing of successes via Twitter. The HCSW reported they feel supported by senior nurses and matrons. The theatre staff demonstrated a high level of commitment to patient care and described improvements since the appointment of the new matron. It was acknowledged that they had a supportive peer network and enjoyed the variety of work, however, the service has outgrown the environment. Use of WhatsApp groups are being used within individual staffing groups to seek support from colleagues. Many theatre staff feel invisible to senior management, and they don't know who the executive team are. Staff are working extra hours at the end of the day, sometimes past 9pm, with this goodwill soon forgotten the next day by senior surgeons. Junior staff rely on anaesthetist intervention to challenge surgical staff during times of unprofessional behaviour. It was reported that there has been a significant increase in occupational health referrals. The

reviewers are concerned regarding the resilience, particularly of new registrants. Junior nurses do not feel empowered to speak up and challenge decision making, they feel unsupported and do not believe that their voice is heard. In addition, it was clear issues were not raised and followed up because there was active discouragement in staff raising concerns and fears about reprisals for individuals. It was reported that theatre staff underwent a staffing review in July, however, outcomes have still not been received. The reviewers were concerned to hear that theatre coordinators face extreme emotional pressure from surgical staff when listing cases which result in perceptions that cases sometimes being inappropriately listed as emergencies. There were reports of inappropriate behaviours of shouting observed in theatres on a regular basis.

Across the two-day visit and discussions which took place in each forum, the shared theme when asked what is good about working within this service, was one of pride to work within such a specialised service. However, it is also recognised that goodwill was high, and it was reported within the focus groups and the group meeting, that situations had reached their lowest point possible and not envisaged to be sustainable.

Good Practice / Significant Achievements

- The open, honesty and candour from all disciplines within all staffing groups.
- The commitment and compassion of the staff to deliver excellent patient care.
- Diversity of services provided within the cardiothoracic board with staff feeling proud to be able to deliver a wide range of speciality services.
- Caring interactions were noted between staff and patients on wards.
- Individual team peer support can be sought and is given with the use of WhatsApp.
- Well-led, open and focused care environment within ITU.
- Well-led, patient centred transplant ward.

- Well supported perfusion team who have clear line management and an accountability structure in place.
- Good support and supervision for junior doctors from the respiratory consultants.
- Web based patient information developed by the heart and lung transplant team.
- Detailed and thorough portfolios of core competencies.

Specify Immediate Risks
An 'Immediate Risk' is an issue that is likely to result in harm to patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action.

1. During the quality peer review visit, a clinical event was reported to the visiting team. A patient scheduled for an operation was taken to the theatre reception/recovery area for surgery, however, due to unplanned leave, the case was covered by an alternative consultant surgeon. On presentation of the patient, the treatment strategy was altered, and a different procedure was undertaken, contrary to the documented MDT decision.

   This change in clinical management strategy so close to a planned procedure could both expose the patient to additional risk and impact on clinical outcomes. It was unclear how the patient was engaged in this change in plans.

Specify Serious Concerns
A 'Serious Concern' is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality of clinical outcomes of patient care and therefore required urgent action to resolve.

1. The reviewers visited several clinical areas. On one ward (Ward 30) observations were (at the time of visiting) overdue, some by up to over four hours. These extensive delays could seriously compromise the quality of patient care, not least because of these inputs are needed for determining Early Warning Scores.

2. The team reviewed case notes, from among those already reviewed at morbidity and mortality meetings. In one case, there was a delay of three months between (upload of) a referral to the response informing the patient that further investigations were required before they could be considered for revascularisation. This delay, which should be in the Trust's control, is excessive and could significantly compromise patient outcomes.

3. The consultant week on ward standard operating procedure was welcome but is far from fully implemented. This has led to clinical decisions, for example about relative priority of patients for transfer, being taken in isolation by nurse practitioners. Nursing staff taking on this responsibility, without senior medical oversight, could expose them to unreasonable professional risk and could seriously compromise the quality of patient care.

4. The level of on call was noted to be very high, with one consultant covering 20 days in a month. This is not an acceptable or safe on-call rota. This process is not sustainable and could significantly impact the health and wellbeing of the individuals.

5. The reviewers were aware that of earlier investigations of culture in this service. They did indeed hear accounts of ongoing adverse and unprofessional behaviours (including allegations of bullying, coercion, harassment, and exclusive work relationships). The reviewers were unable to validate each one of these accounts, nor did they have the remit or resource to assess the extent of these behaviours. The reviewers were reassured that the management team and Trust did indeed have action plans in place on culture within the service, however, remained concerned about the impact of these on both staff wellbeing and patient safety.

6. There is a lack of confidence in the freedom to speak up guardian process by members of staff. Further, the freedom to speak up guardians' line management was believed to impact on the success and trust of the process. This is also significantly impacting the health and wellbeing of staff.

7. Several staff expressed a lack of confidence in the Datix risk management information system and underlying Trust processes, specifically, outputs of the system are not being made visible to reporters, and there is no reports of feedback or learning being made. Further, staff gave examples to the team of inappropriate amendment of Datix entries. Failings in incident reporting could seriously compromise the quality of clinical care as well as staff health and wellbeing.

8. The team heard accounts of changes to treatment plans being carried out without patient consent. Staff also reported concerns about the timing and recording of consent in relation to procedures being undertaken, as well as questioning the fidelity of recording. This is a safeguarding concern.

9. Staff raised concerns about attribution and supervision of surgical activity. Some cardiac surgical activity is currently being attributed as the work of one of your senior surgeons, whilst senior fellows are carrying out procedures unaccompanied, and without direct supervision. Whilst being on hand in case of emergency, the named lead consultant is not present.

10. The lack of an in-house urgent waiting list is unacceptable. This is causing emergency patients to face significant delays for procedures. This could seriously compromise the quality of clinical outcomes.

Areas of Improvement
• Senior management should be more visible and engaged with the service and review communication strategies. • A team approach is required between clinicians and management to create a better working environment. • Job plans require adequate protected time to allow individuals to carry out both their clinical and management duties. • Robust processes should be followed in recruitment and expressions of interest. • Feedback should be disseminated appropriately to teams, for example, outcomes of staff surveys. • Attention should be given to the language of patient information being more patient friendly and not as clinical. • Consideration should be given to the web-based patient information resource, developed by the transplant coordinators, being rolled out across all cardiothoracic areas. • A review of workstations for ward staff to enable timely and robust data entry. • Consideration should be given to provide mentorship and coaching to the lead clinicians/clinical directors to reflect on how they might approach challenges. • The MDT attendance by core members and attendance recording needs to be reviewed. • Treatment plans should not be operator dependent but should be based on the consensus of MDT. • Review the prioritisation meetings and application of processes and the limitations of the post operative recovery provision. • The WHO surgical safety checklist should be consistently adhered to and completed. • Review the capacity of the echo service which is impacting on patient decision making.

- Ensure a robust document control process is in place and implemented for review of clinical guidelines and patient pathways.
- Consideration should be given to the recruitment of a data entry clerk for service/clinical board.
- Progress and implementation of the six recommendations listed in the NACSA summary report 2023 should be managed.
- A local audit programme should be implemented to review working practices, with shared learning being disseminated.
- Individual clinical supervision should be introduced to aid with the health and wellbeing of staff within the service.
- The risk register should be reviewed and actively managed to reduce risk and identify issues.

Name of Board Representative feedback was presented to:
Martin Wilson – Chief Operating Officer