Invited Service Review Report

Royal College of Surgeons of England
ADVANCING SURGICAL CARE

Report on the adult cardiac surgical service

The Newcastle-upon-Tyne Hospitals NHS Foundation Trust

Review visit carried out on: 28 – 30 April 2021

Report issued: 23 July 2021

A service review on behalf of:	**Review team:**
The Royal College of Surgeons of England	[redacted]
The Society for Cardiothoracic Surgery	[redacted]
Lay reviewer	[redacted]

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1. Introduction and background

On 19 February 2021, Mr Andrew Welch, Medical Director for The Newcastle-upon-Tyne Hospitals NHS Foundation Trust ("the Trust") wrote to the Chair of the Invited Review Mechanism (IRM) to request an invited service review of the Trust's adult cardiac surgical service ("the unit"). In particular, the request highlighted concerns about departmental culture including allegations of bullying by adult cardiac consultant surgeons towards consultant surgeons and trainees, issues with attendance at and the efficacy of the MDT meetings, and a discord within unit regarding the allocation of 'unstable' cases.

This request was considered by the Chair of the Royal College of Surgeons for England (RCS Eng) IRM and a representative of The Society for Cardiothoracic Surgery and it was agreed that an invited service review would take place.

A review team was appointed, and an invited review was held remotely, using video conferencing facilities, on 28 – 30 April 2021. The appendices to this report list the members of the review team, the individuals interviewed, the service overview information, the documents provided to the review team and the clinical records reviewed.

Overview of healthcare organisation and the cardiothoracic service at the time of the review request.[1]

The Trust is one of the largest teaching NHS foundation trusts, with a catchment population of 1.7 million including Northumberland, Tyne & Wear, North Cumbria and North Durham/Sunderland area and provides tertiary cardiac services including transplantation to a larger catchment area, including Scotland. The Trust also runs a speciality service at a satellite clinic in Carlisle once a week.

The information provided at the time of the review indicated that the unit was comprised of seven adult cardiac consultant surgeons (one of which was a locum) within the speciality service, three congenital cardiac surgeons and four thoracic surgeons (a fifth being a vacant post). In addition, there were eight surgical registrar posts (five of which are trust grade doctor positions), nine National Training Number (NTN) registrars and two non-NTN registrars, and five transplant fellow positions.

The consultant surgeons operated a 'hybrid on call', comprising of transplant rota 1:5 (two consultants non-involved) and general cardiac surgery 1:6 (one consultant non-involved) and all undertaking surgery for acute type A aortic dissection.

There were 37 service dedicated ward beds (this was 31 pre-Covid-19), 16 ICU beds and 6 HDU beds. Five theatres were utilised by the unit (one dedicated for Thoracic, one for Congenital, two for Cardiac and one for Emergency).

In terms of the service surgical activity over the last two years, there have been 649 elective cases and 451 non-elective cases performed. For cardiac surgery, the numbers of 'day cases' performed were 3 and 9 respectively for the same two years and there were also 117 and 110 emergency procedures.

[1] Provided in the service overview information at Appendix C

2. Terms of reference for the review

The following terms of reference for this review were agreed prior to the RCS England review visit between the RCS England and the healthcare organisation commissioning the review.

Background

The review team will consider the standard of care, clinical management, training and leadership provided by the adult cardiac surgery service, following concerns raised about the interpersonal professional relationships between adult cardiac consultant surgeons, consultant surgeons and cardiac trainees, which has culminated in allegations of bullying and division within the unit.

Concerns have been raised regarding the efficacy of MDT decisions, behaviours at consultant meetings and a discord within the department regarding the process of selection and distribution of cases, and whether the level of supervision and/or the choice of assistance was appropriate.

Review

The review will involve:

- Consideration of background documentation regarding the adult cardiac surgery service.
- A clinical records review of 13 randomly selected cases put forward by the Trust.
- Interviews with members of the cardiac surgery service, those working with them to provide the service and other relevant members of healthcare organisation staff.

Terms of Reference

In conducting the review, the review team will consider the standard of care provided by the adult cardiac surgery service, including with specific reference to:

- Standards of interpersonal behaviours and communication in the cardiac surgical service between consultants, cardiac trainees and other clinicians within the unit, including but not limited to allegations of bullying/factions.

- Standards of team working including multidisciplinary processes and insights into the efficacy of MDTs.

- The quality of clinical leadership in the cardiothoracic surgical service.

- The level of support and quality of training provided to trainees and consultant surgeons within the cardiac surgical service.

- Whether the management, selection and distribution of cases, particularly the management of unstable cases and delegation of cases to fellows, within the cardiac surgical service is fair/equitable.

- Whether there has been any potential impact to the quality of clinical outcomes and to patient safety as a result of these factors.

Conclusions and recommendations

The review team will, where appropriate:

- Form conclusions as to the standard of care provided by the adult cardiac surgery service including whether there is a basis for concern in light of the findings of the review.

- Make recommendations for the consideration of the Medical Director of the Trust as to courses of action which may be taken to address any specific areas of concern which have been identified or otherwise improve patient care.

The above terms of reference were agreed by the College, the healthcare organisation and the review team on 7 April 2021.

3. Conclusions

The following conclusions are based on the information provided to the review team from the interviews held, the documentation submitted, and a review of the clinical records submitted by the trust. They are largely organised according to the Terms of Reference (ToR) agreed prior to the review but also take account of the themes that emerged whilst reviewing this information.

3.1. Standards of interpersonal behaviours and communication in the cardiac surgical service between consultants, cardiac trainees and other clinicians within the unit, including, but not limited to, allegations of bullying/factions.

The review team concluded that the polarisation and breakdown of relationships in the cardiac surgical department have gravely impacted the ability for the unit to function as a cohesive and mutually supportive team. With the lack of data provided by the Trust in respect of the clinical records, the review team could not conclude whether patient safety had been compromised as a consequence of the factionalism. However, they were concerned there was the potential for this to happen going forward if the unit continued to operate in such a divisive way. The review team, therefore, viewed that external professional mediation and the recruitment of additional staff was required to improve interpersonal relationships across the unit and lead to a better working environment.

In reaching their decision, the review team learned, from the numerous reports at interview, that there were longstanding issues of serious and substantial team working difficulties within the unit. These appeared to have worsened over the last two to three years and had extended beyond the consultant adult cardiac surgeons into anaesthesia, cardiology, nursing, junior medical staff and allied professionals.

The service was also described by some interviewees as being a 'dysfunctional' and 'toxic' environment in which to work. It became apparent to the review team that deep-seated 'factions' had formed within the unit and that many staff – particularly junior members of the team - were being manipulated by senior consultants belonging to one or the other faction to further divisions. This was also affecting some of the staff members' mental and physical wellbeing. It was understood that those staff did not feel able to challenge difficult or 'bullying' behaviour in fear of retribution or that their career advancement would suffer in some way.

The review team noted that not all staff shared this view, some interviewees described consultants as being very approachable and that they had not witnessed any 'bullying' behaviour. It was apparent to the review team that some experienced staff had more confidence in confronting difficult behaviour and appeared to be almost dismissive or oblivious to some of the complaints being reported. The review team were concerned that these attitudes may have contributed to the anxieties of other staff to confront or report poor behaviour in the belief that they would not be appropriately supported when doing so. This in turn allowed for a culture of negative behaviours to be replicated and embedded over time.

The review team were also provided information that, following a recent staff survey[2], cardiothoracic surgeons were noted as being 'exhausted' and suffering from burn out. The review team had noted that there were a number of vacant posts[3] in the unit, reportedly, there was no endocarditis lead in place and the aortic service appeared to be run by one consultant which, given the volume of work and the associated risks, was not considered by the team to be appropriate.

[2] *75% staff suffering 'burnout'; SCORE Survey Culture and Engagement Survey Results, 2019*

[3] *Vacancies numbers listed at Appendix A - Information provided to the review team & Appendix C – Service overview information*

In addition, the review team were informed of there being 'difficulties' in creating additional posts despite a reported under spend of half a million pounds in the last financial period. In the review team's opinion, the workload pressures may have had an impact on staff morale and contributed to a culture of blame and divisiveness in the unit.

3.2. Standards of team working including multidisciplinary processes and insights into the efficacy of MDTs[4].

3.2.1. Standards of team working

Following the various accounts at interview together with the information provided, the review team concluded that the team was not working as a cohesive unit. Whilst the review team learned that colleagues were inclined to 'double scrub' when requested to, there were also reports of some cardiac consultants not seeking assistance from fellow consultants on procedures due to a breakdown in their professional relationship, which was concerning.

The review team noted that the Trust had recently introduced a 'Consultant of the week' to streamline the on-call system and ward attendance. From the various reports at interview and the sample of clinical records provided[5], the review team regarded that this system was badly managed and had led to a 'blurring' of the consultant responsibilities for patients' care, with many decisions being changed or reversed by the named consultant. It was also understood that the commitment to the role differed between consultants and many interviewees, including trainees, ward nursing staff and ANPs[6] described consultants' attendance at ward rounds as varied and that they were often left to manage patients' care.

The review team considered that the 'Consultant of the week' process could achieve positive results if all consultants embraced it fully and there was a mutual trust between consultants in each other's decision making.

3.2.2. Insights into the efficacy of MDTs

From the majority of accounts at interview and the sample of clinical records reviewed, the review team were concerned that the MDT meetings were not transparent or collegiate in spirit, with insufficient time for mature case discussions, and that 'corridor meetings' had become habitual in resolving issues around case plans.

The review team learned that, due to the pervading factionalism within the unit, MDT meetings were not found to be welcoming places to foster engagement between consultants, and this in turn had led to poor attendance at some of the meetings[7]. It was also of concern to the review team that some surgeons had chosen not to attend the meetings as they did not want to be associated with the poor practice in the recording of the decision-making.

Similarly Morbidity and Mortality (M&M) meetings were also poorly attended; interviewees describing meetings as challenging due to the strength of personalities of certain consultants attending the meetings. This had made the meetings quite 'regimented' rather than an environment to encourage learning and purposeful debate. The review team considered that the lack of formal M&Ms was unacceptable and they were also concerned about the negative effect on the unit if staff lacked confidence in reporting any 'near misses' and other aspects of patient care at these meetings.

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[4] Multidisciplinary Teams
[5] Clinical patient records can be found at Appendix B
[6] Advanced Nurse Practitioners
[7] Attendance details outlined in interview notes at Appendix A - Information provided to the review team

The review team concluded that working relationships at multidisciplinary meetings could be better improved if there was a structured process to ensure meetings were held at the appropriate time and of sufficient frequency and setting out a code of conduct for the meetings and what is acceptable behaviour. It was also understood that MDTs occur across multiple sites which made it difficult to ensure everyone was in the same room to discuss patient cases. In view of this, the review team considered that the Trust should look to utilising the resources available, such as holding meetings online if staff were unable to be physically present.

3.3. The quality of clinical leadership in the cardiothoracic surgical service.

The review team concluded that interpersonal and behavioural issues in the unit were perpetuated by a lack of intervention at an executive level. The review team noted, from the accounts provided at interview, that there appeared to be a reluctance by some senior staff to take responsibility or effective action to resolve the factionalism. This has contributed to issues continuing within the unit for a prolonged period of time and staff losing confidence in management to remedy or manage situations appropriately.[8]

The review team noted that there has been a number of changes to the directorate in the past few years. The Head of Department left the post in 2018 and the current Clinical Director had only been in post since October 2018. The review team were also concerned by reports that the transplantation service appeared to be struggling following the retirement of the Head of Transplantation who had been described as 'passionate' about the service. The review team considered that it was possible that these personnel changes had contributed to the divisions within unit.

The review team also noted that a member of the executive team had previously been suspended from post for a period of two months following a complaint from a trainee about their conduct. Whilst the suspension was outside the review team's remit to explore further, the review team were concerned that the management's communication about the suspension had been poor. The review team accepted that details about the suspension were confidential, however, the reported manner of this suspension reinforced a lack of clear consistent direction from the executive team or a desire to learn from the incident.

In addition, during the interviews the review team were made aware that the aortic service had been temporarily suspended[9]. Although this matter was outside the terms of reference of this service review, the review team were concerned that management had not appropriately communicated this decision to the unit, which in turn had caused distress among some of the cardiac consultants, one of whom had only learned of the suspension during the invited review process. The review team considered that this service appeared to be struggling, and it would be counterintuitive to expand this service until the infrastructure and support for this service had been addressed. The review team considered that the Trust's leadership team needed to take responsibility for effecting such changes.

The review team noted that staff were aware of the Human Resources policies and procedures[10] and Datix[11] system, but reportedly not all staff were confident in using those processes as, specifically to incident records on Datix records, there were concerns with these being kept anonymous. The review team did not have any information to corroborate that this was the case,

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[8] SCORE survey (2019) detailed over 50% staff were disaffected with the leadership.

[9] The service was suspended near the end of April 2020 for debrief following the death of a patient, this was reinstated a few days later.

[10] List of policies can be found at Appendix D – Documents received during the review

[11] Datix is an electronic incident reporting system.

although the accounts provided at interview further demonstrated a mistrust of management to handle complaints fairly and transparently.

The reviewers also learned that mediation was attempted a few years previously, but was reportedly withdrawn by a member of the clinical management team at that time as it was considered no longer necessary to engage in the process; this was despite consultants being willing to engage in the process. It was clear, from the accounts provided at interview to the review team, that some staff were sceptical that engaging in the mediation process alone would help resolve the issues in the unit and that more direct action was required by management to address the factionalism. However, many of the staff interviewed did not appear to have full confidence in management to achieve this.

The review team were concerned that some of the senior appeared reticent to take responsibility or close the loop on some of the issues reported above, and they appeared to defer responsibility to another member of the directorate. The inability to effectively demonstrably positive action in an even-handed way was of concern for the review team. The team considered that the factionalism was not only damaging the unit but the reputation of the Trust, and it required strong leadership to resolve the issues.

3.4. The level of support and quality of training provided to trainees and consultant surgeons within the cardiac surgical service

The review team concluded that the training programme at the Trust was not being managed appropriately and that trainees were working in an uncomfortable and difficult environment which inhibited learning and development.

The review team heard numerous reports of trainees and junior clinicians experiencing bullying and reportedly discriminatory behaviour based on gender towards them by senior members of the team, with some reports that trainees were questioned on their competency to undertake routine procedures or being ordered to leave theatre without any justification. Although the review team were not in the position to substantiate the allegations, it was noted there was a perception among many interviewees that female trainees were treated differently to their male peers. This perception could be partly attributed to trainees being affected by the factionalism existing in the unit.

The review team considered that the training programme at the Trust was outdated in contrast to James Cook University Hospital[12] where trainees appeared to thrive. It was reported that trainees had to proactively seek out training opportunities at the Trust or were being side-lined for routine procedures which they were normally entrusted to undertake at James Cook. The review team noted that this had affected trainees' confidence in their competency to carry out standard procedures and many were concerned that the lack of formal training would affect their career advancement in the long-term.

The review team considered that some of those at the Trust involved with the clinical supervision and educational programme had a poor understanding of what the training programme entailed and what support should be in place. This was a view also shared by some interviewees who described being powerless to effect changes to the training programme.

The review team were saddened to learn of trainees feeling undermined and mistreated by senior consultants and that their wellbeing was being affected by the factionalism in the unit. The review team considered that the culture around training in the unit needed to significantly improve. This would require substantial development for many of the consultant trainers in the unit and appropriate senior support. Until such a time, the reviewers recommended that the Trust should work with the regional training programme and Postgraduate Medical Dean to revise the training programme, which would include removing NTN trainees in adult cardiac surgery posts for a

[12] *James Cook University Hospital is a designated major trauma centre in Middlesbrough.*

temporary period to protect their wellbeing. The review team also considered that any allegations of bullying should be robustly investigated by the Trust and, if proven, the appropriate action taken against the perpetrators.

3.5. Whether the management, selection and distribution of cases, particularly the management of unstable cases and delegation of cases to Fellows, within the cardiac surgical service is fair/equitable.

The review team concluded that the general management, selection and distribution of the cases did not appear to be equitable and there did not appear to be a collegiate way of working within the unit.

A number of interviewees reported that some patients (many of which were referrals from nearby hospitals in the region) could be left waiting an inordinate amount of time for surgery to take place due to some consultants not taking responsibility for their care. The review team also heard that the delays to surgery were also compounded by some surgeons deciding to change the patient's treatment plan from what was agreed at referral.

It was understood that there was supposed to be a cap on waiting lists for each consultant to ensure that any new referrals would be given to the consultant with the least number of cases on the waiting list. However, the review team heard that some consultants were reportedly selecting more straightforward cases.

The review team learned that the allocation system for unstable cases had been changed in March 2020, as a result of the Covid-19 pandemic. The Trust provided information that the waiting list time from point of referral to surgical procedure had reduced to an average of 5.5 days. This was deemed by staff to be an improvement on the previous system which averaged at 7.5 days for point of referral to surgical procedure. It was understood that in-house cases were coordinated by the Coordinating Consultant Surgeon (presently a Locum) who would allocate patients considered 'ready' for surgery to the surgeon with the next available unstable operating slot. However, from various accounts provided at interview, the system for allocation appeared opaque to the review team as many patients were not considered 'ready' by the surgeon to whom they were allocated. It also did not appear, from interview accounts, that cases were being distributed equally.

From the clinical records reviewed, the review team also noted that there was not a clear record of decision-making for unstable cases as some patients were being sent for PCI[13] rather than CABG[14] procedures[15], despite an initial decision to undertake CABG, without any clear rationale or evidence for this decision or record of subsequent MDT discussions having taken place. It was also noted that surgical outpatient clinics were held on the same day which the review team considered to be unusual and which could have had implications around the availability of personnel that day.

The review team concluded that, given the inconsistencies of surgical workload and the apparent lack of continuity of care for patients, a more robust system for auditing case allocation across the unit was required.

[13] *Percutaneous coronary intervention*
[14] *Coronary artery bypass grafting*
[15] *Cases A2, A3 and A6 at Appendix B – Clinical record review notes*

3.6. Whether there has been any potential impact to the quality of clinical outcomes and to patient safety as a result of these factors.

As part of this review, the review team were provided a sample of thirteen clinical records to consider if there had been an impact to quality of clinical outcomes and to patient safety.

The review team were concerned, from the clinical records viewed[16], that there appeared to be a lack of responsibility or ownership for patient care, a lack of formal recording of MDTs and decisions relating to the patient surgical pathway. Despite the review team's concerns, the review team did not consider, from the clinical records viewed, that any of the patients required clinical follow up.

The team also noted, from one of clinical records provided[17], that the patient had sadly died. The review team considered that this was a complex case and that it was not possible to conclude, from the limited information provided, that the divisions in the unit had any bearing on the outcome of the patient's care for this case. However, it was noted that the review team had only seen a small sample of clinical records from the Trust and were concerned that, if the divisions continued within the unit, this would inevitably lead to risks in patient care and safety.

The review team were also of the opinion that there are excellent speciality services offered by the Trust, such as the transplantation service which was the first to be offered in the UK. It was evident from many interviewee accounts that they were proud of this service and wanted it to succeed. However, in the review team's opinion, the factionalism was damaging the reputation of the department.

The review team wanted to acknowledge that this review was a significant positive step taken by the Trust to move forward to improve interpersonal relationships so that the best patient care is provided at the hospital. However, this would require a lot of work which would take many months to plan and imbed.

[16] Cases: A1, A2, A3, A4, A5, A6, A7, A8, A9, A10, A11, A12 & A13 at Appendix B – Clinical record review notes

[17] Case: A10 at Appendix B – Clinical record review notes

4. Recommendations

4.1. Urgent recommendations to address patient safety risks

The recommendations below are considered to be highly important actions for the healthcare organisation to take to ensure patient safety is protected.

1. The Trust must encourage learning and engagement across the Directorate to improve interpersonal relationships and to effect positive change. The Trust should consider professional mediation to facilitate this process. The RCS Eng's *"Managing disruptive behaviours in surgery"* [18]document provides some useful guidance.
2. Personnel changes and/or creation of new posts must be actioned to further assist the improvement of cultural behaviours in the unit.
3. The Trust should work with the regional training programme and postgraduate medical dean to improve its trainee programme, which requires removing trainees with a 'National Training Number' from adult cardiac surgery posts for a temporary period to protect their wellbeing.

4.2. Recommendations for service improvement

The following recommendations are considered important actions to be taken by the healthcare organisation to improve the service.

4. The Trust should investigate and address any claims of bullying and sex discrimination sensitively and even-handedly.
5. There should be a robust mechanism for reporting on the DATIX system and a learning/ feedback exercise outlining any trends and how these will be positively addressed. Assurances should be given that any feedback will be treated in confidence.
6. The Trust should revise the current 'unstable cases' and for out of hours procedures, clarifying consultant surgeons' responsibilities. All consultants should have an input into the development of the revised process and all views/opinions should be respected.
7. Given the important regional transplant and mechanical support, and aortic services provided, the Trust should ensure that the aortic and transplant services processes are improved and the appropriate support is provided to team members. The aortic service could be strengthened by the appointment of a second consultant cardiac surgeon with an aorto-vascular interest. The team, in association with vascular surgery and interventional radiology should, taking into account likely demand, decide the scope of the interventions they will undertake and where necessary arrange training and proctoring for the whole team to develop these skills. They should develop necessary, common protocols, especially for follow-up of patients after aorto-vascular surgery and aortic dissection.
8. Leadership and managers should embark on a programme to improve their communication and coaching/mentoring skills. The RCS Eng's *"Surgical Leadership: A guide to best practice"*[19] document provides some useful guidance.
9. There should be formal documentation and a clear audit of any decision making and action points being noted for MDT and M&M meetings, and other interdepartmental MDTs.
10. The Trust should consider creating the role of a dedicated MDT Coordinator to attend the meetings to ensure notes were accurately recorded and disseminated following the

[18] *https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/managing-disruptive-behaviours*
[19] *https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/leadership*

meetings. Each consultant's job plan should also be updated to incorporate dedicated time for MDT attendance.

11. The Trust should draw up a formal code of conduct of expected behaviours at MDT and M&M meetings. This would entail the agreement of the affected personnel to actively apply the code.

4.3. Additional recommendations for consideration

The following recommendations are for the healthcare organisation to consider as part of its future development of the service.

12. The Trust should take steps to ensure that clear and comprehensive systems are put in place to monitor the quality and safety of the ongoing operative outcomes of the service, and to ensure that these continue to exist within nationally understood parameters for cardiothoracic surgical services. This should include contemporaneous monitoring of surgical outcomes and early review and discussion of any unexpected outcomes or surgical complications.

4.4. Responsibilities in relation to this report

This report has been prepared by The Royal College of Surgeons of England and The Society for Cardiothoracic Surgery (SCTS) under the IRM for submission to the healthcare organisation which commissioned the invited review. It is an advisory document and it is for the healthcare organisation concerned to consider any conclusions and recommendations reached and to determine subsequent action.

It is also the responsibility of the healthcare organisation to review the content of this report and in the light of these contents take any action that is considered appropriate to protect patient safety and ensure that patients have received communication in line with the responsibilities set out in the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Regulation 20.[20]

4.5. Further contact with the Royal College of Surgeons of England

Where recommendations have been made that relate to patient safety issues the Royal College of Surgeons of England will follow up with the healthcare organisation that commissioned the invited review to ask it to confirm that it has taken to action to address these recommendations.

If further support is required by the healthcare organisation, the College may be able to facilitate this. If the healthcare organisation considers that a further review would help to assess what improvements have been made the College's Invited Review service may also be able to provide this assistance.

[20] *The Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014: http://www.legislation.gov.uk/uksi/2014/2936/contents/made*