

Trust Board Meeting: Wednesday 13 November 2013

TB2013.122

Title	Independent Review Report of Cardiac Theatres and the Cardiac Surgical Unit
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Status	For discussion and decision
History	Trust Board, March 2013 Trust Board, September 2013

Board Lead(s)	Paul Brennan, Director of Clinical Services			
Key purpose	Strategy	Assurance	Policy	Performance

Executive Summary

1. This paper presents the report of the Independent Review of Cardiac Theatres and the Cardiac Surgical unit to the Trust Board for discussion. The review was commissioned by the Trust in April 2013 and was conducted over the period May – August 2013.
2. The review was commissioned by the Chief Executive following concerns raised internally by some cardiac staff and via a whistle-blower complaint to the Care Quality Commission in March 2013.
3. The review team reported that there are no current patient safety concerns in the cardiac unit but that there are a number of improvements that could be made to ensure continued safe levels of care.
4. The report details 37 recommendations for the Trust Board's consideration.

5. Recommendation

The Trust Board is asked to:

- **Discuss** the report and its recommendations as attached at Appendix 1
- **Note** the comments provided by the Independent Oversight Group in Section 6
- **Approve** the actions described in Action Plan attached as Appendix 2

Independent Review Report of Cardiac Theatres and the Cardiac Surgical Unit

1. Purpose

- 1.1. This paper presents the report of the Independent Review of Cardiac Theatres and the Cardiac Surgical unit to the Trust Board for discussion. The review was commissioned by the Trust in April 2013 and was conducted over the period May – August 2013.

2. Background

- 2.1. In February 2013, a concern was raised internally within the Trust by a member of staff about the staffing arrangements in the cardiac theatres team.
- 2.2. The Medical Director agreed to investigate those concerns and notified the Trust Board of his intended action at the Trust Board meeting in March 2013.
- 2.3. On 12th March, the Care Quality Commissioner (CQC) contacted the Trust to inform them that an individual member of staff had raised a whistle-blowing concern with them directly. The whistle-blower alleged that there were issues of patient safety within the cardiac surgical unit, particularly relating to staffing, and that the Trust's senior management had failed to respond over a number of years to concerns raised by staff in the unit regarding patient safety based on staffing arrangements. The CQC requested a response from the Trust within 14 days.
- 2.4. Given the nature of the concerns and the fact that these had been raised via the internal system and through whistle-blowing to the external regulator, the Chief Executive decided to commission an external independent review of the issues raised rather than completing the original action notified to the Board in March 2013.
- 2.5. Board members were briefed on this course of action and CQC were notified as requested within the 14 day period. CQC were supportive of this open and transparent approach.
- 2.6. In addition, the Chief Executive asked the Medical Director to provide assurance that there were no immediate clinical governance concerns in the unit. On 16th April, the Medical Director provided a written response to the Chief Executive outlining that there were no immediate issues of concern identified from clinical outcome data (including mortality) or from other clinical governance data held by the Trust. This letter was circulated to all Board members.

3. Objectives and process of the External Independent Cardiac Review

- 3.1. Following receipt of the concerns from CQC, the Chief Executive supported by the Medical Director, Director of Clinical Services and Director of Assurance developed Terms of Reference which were shared with the CQC for their

approval of the approach and scope of the review. This approval was received on 16th April 2013.

- 3.2. The key objective of the review was to conduct an investigation which delivered independent scrutiny of Cardiac Theatres and Cardiac Surgical Unit which;
 - Identified and addressed any relevant concerns arising during the review, in relation to patient safety and staffing within cardiac theatres; and
 - Investigated and commented upon OUH's response to identified issues regarding patient safety and/or staffing since Spring 2010 to date within Cardiac Theatres, with specific regard to the scope, adequacy and effectiveness of that response.
- 3.3. In order to establish an independent multi-disciplinary team of reviewers to conduct a thorough investigation, Sir Jonathan Michael, Chief Executive sought recommendations for a cardiac surgeon to be asked to undertake the review from Sir Bruce Keogh, Medical Director of NHS England.
- 3.4. Other colleagues in the review team were selected based on recommendations from Chief Nurses in other university or teaching trusts with cardiac surgical units.
- 3.5. The external review team was established with the following membership:
 - Professor John Wallwork, retired Consultant Cardiac Surgeon; Papworth Hospital NHS Foundation Trust
 - Steve Livesey, Consultant Cardiac Surgeon, University Hospital Southampton NHS Foundation Trust
 - Sue Langley, Head of Nursing, Division of Specialist Medical Services; Central Manchester University Hospitals NHS Foundation Trust
 - Lisa Locker, Cardiothoracic Matron, Sheffield Teaching Hospitals NHS Foundation Trust
 - Susan Stoker, Independent management Consultant (Governance).
- 3.6. Professor Wallwork was invited to be the lead reviewer, responsible for the co-ordination of the investigation and production of the final review report.

4. Openness and Transparency

- 4.1. In establishing the Terms of Reference, the Chief Executive decided that this review should be conducted in an open and transparent manner and that all staff involved in the unit should be encouraged to share their experiences to enable the investigation to identify any shortfalls in standards of care.

- 4.2. All staff within the cardiac unit were briefed via open meetings with the Medical Director and Director of Clinical Services as well as receiving a letter explaining the nature and purpose of the review. Staff were encouraged to participate openly and honestly with the external review team.
- 4.3. In addition, the Chief Executive established an “Independent Oversight Group” (IOG) with a remit to ensure the review team had appropriate access to staff and documentary evidence; and that the investigation (and subsequent report) was delivered in a timely and effective manner against the agreed Terms of Reference.
- 4.4. The membership of Independent Oversight Group was:
 - Peter Ward, Non-Executive Director and Chair of the IOG
 - Eileen Walsh, Director of Assurance
 - Bennett Low, Assistant Director of Nursing (Quality Assurance), NHS England.
- 4.5. The CQC were invited to join this group but declined in order to remain completely independent. However it was agreed that the IOG would provide regular progress updates to the CQC throughout the process and that if findings on potential patient safety issues were identified in the course of investigation that these would be notified immediately to CQC.

5. Investigation Process

- 5.1. The review team commenced the investigation in early May and during the course of the review, over 20 days (across the review team) were spent on site interviewing 49 staff, attending meetings and re-interviewing key staff, where necessary, to triangulate findings. The review team scrutinised approximately 55 different sets of data/documentation related to the operation and performance of the cardiac unit. All findings were cross referenced and triangulated with staff interviews and documentation provided.
- 5.2. The initial timescale for completion was anticipated to take eight weeks from commencement (mid-July). However, as a large number of staff wished to be interviewed, sometimes on more than one occasion, the review team requested permission from the Independent Oversight Group to extend the timescale to 31st August to facilitate the widest participation by all interested staff. This extension was agreed by IOG.
- 5.3. The review process has now been completed and the draft report was provided to the Chief Executive on 27 August 2013 for factual accuracy checking. The Chief Executive met with the lead reviewer, Professor Wallwork and one other member of the review team on 29 August 2013 to discuss the report and to agree any amendments required on factual accuracy.
- 5.4. The final report was received on 2 September 2013 and was immediately submitted to the IOG for their consideration of the content against the approved Terms of Reference. The report is attached as Appendix 1.

6. Independent Oversight Group Opinion

- 6.1. The IOG convened on a regular basis throughout the investigation. It received updates from the lead reviewer on progress and facilitated the release of any information requested by the review team. The IOG also met with the Chief Executive to establish the process for handling the receipt of the final report. The group ensured that the CQC received regular updates on progress following each IOG discussion.
- 6.2. As mentioned above the IOG received the final report on 2 September 2013 and on 3 September 2013 the Chairman of the IOG convened a meeting to discuss its content relative to the approved Terms of Reference for the review and subsequently wrote to the Chief Executive to confirm the view of IOG.
- 6.3. Overall the IOG was satisfied that the report addressed all aspects of the Terms of Reference (ToR). However it noted a small number of comments in relation to specific details within the ToR as follows:
 - 6.3.1. In relation to the sections on patient safety, the IOG welcomed the fact that the review team did not find any immediate patient safety concerns. However, in relation to the requirement *“to identify any objective evidence of patient safety concerns within the unit, considering outcomes data, case mix and any specific concerns raised by staff at interview”*, the IOG would have preferred more quantitative analysis to have been included in this section of the report (paragraphs 4.7 to 4.10). The IOG accepts that the review team analysed significant quantities of information in reaching its conclusions in the report. Therefore the IOG suggests that the review team should make available its analysis of the clinical outcomes, case mix and review of other material, where relevant, to the Chief Executive.
 - 6.3.2. In relation to the section on raising concerns, the IOG welcomed the fact that the review team found staff members were aware how to raise concerns in the unit. It reported that nursing colleagues find it easy to raise concerns within the unit (paragraph 4.90). However the IOG agreed that the review team did not explicitly state whether this was the experience of other staff groups. It was discussed that this may be due to the style of report writing but the IOG decided to highlight this issue as remaining potentially incomplete and agreed that this should be confirmed with the review team.
 - 6.3.3. The IOG reviewed the recommendations detailed in section 5 of the report and concluded that recommendations were made to address the key findings of the report and that these corresponded to the specific Terms of Reference. However the IOG wished to highlight their view that the Trust Board will need to ensure that very detailed and specific actions are developed to support the recommendations, if they are accepted by the Trust Board, as the IOG agreed that some recommendations were described at a high level rather than as a specific action.

7. Key Findings

- 7.1. The external independent review of Cardiac Theatres and Cardiac Surgical Unit concluded that there were not any current patient safety concerns and that where concerns had been raised, they had been responded to in a reasonable manner.
- 7.2. The review team made 37 recommendations to support further improvement and development within the cardiac unit.

8. Immediate actions following receipt of External Independent Report

- 8.1. The Trust Board discussed the report at its September meeting (Part2) and decided that before they would accept the recommendations, a detailed action plan should be developed with the staff involvement from the cardiac services.
- 8.2. The Trust Board agreed that the full report and detailed action plan should be submitted to its public meeting in November.
- 8.3. The report and initial response was shared with all relevant stakeholders, including cardiac staff and CQC, in a timely and appropriate manner.

9. Recommendation

9.1. The Trust Board:

- **Discuss** the report and its recommendations attached as Appendix 1
- **Note** the comments provided by the Independent Oversight Group in Section 6
- **Approve** the actions described in the Action Plan attached as Appendix 2

Paul Brennan
Director of Clinical Services

November 2013

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OXFORD UNIVERSITY HOSPITALS NHS TRUST

APPENDIX 1

**INDEPENDENT REVIEW OF CARDIAC
THEATRES and THE CARDIAC SURGICAL
UNIT**

SEPTEMBER 2013

**Professor John Wallwork
Steve Livesey
Sue Langley
Lisa Locker
Susan Stoker**

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Executive Summary

In March 2013 the Chief Executive of Oxford University Hospitals NHS Trust ('the Trust') commissioned an independent review of cardiac theatres and the wider cardiac surgical unit as appropriate, with the focus on staffing; both levels and competency, and their potential impact on patient safety.

This review was commissioned on a background of concerns raised about the safety of cardiac surgery at the Oxford Heart Centre (OHC). More specifically around the level of staffing and competencies in the theatre environment and a subsequent whistle blower complaint about compromised patient safety to the Care Quality Commission (CQC) on 12th March 2013. The terms of reference acknowledged that the cardiac services within the Trust have undergone prolonged periods of scrutiny and strained internal relationships going back over a number of years.

Over many years and particularly since 2010/11, when the divisional structure of management was established, there have been from individual surgeons and collectively concerns raised about theatre staffing related to the lack of recruitment to Surgical Care Practitioners (SCPs) and Perfusionist posts and the reliance on locum staff.

The complaints leading up to the whistle blowing event by an individual, centred around the lack of confidence felt by some of the surgeons of the ability and competence of the locums in theatre, especially the SCPs, leading to poor team dynamics and thus potential safety in complex operations.

There was also a general frustration at the pace of recruitment to full-time posts. This was deepening existing tensions between surgeons and directorate and divisional management. Recruitment to posts in Oxford has been difficult; compounded by its proximity to London and with the reputation of the Unit being a factor. The Trust has addressed this issue, in part, by applying higher grading to certain roles where appropriate.

The objective of the review was to provide a report, based on the independent scrutiny of the Review Team, which identified and addressed concerns in relation to patient safety and staffing within cardiac theatres and identified and commented upon the Trust's response to issues raised regarding patient safety and staffing numbers.

The terms of reference supporting the overall objective, as defined by the Trust, were wide and made reference to a number of different terms in relation to cardiac; 'unit', 'service' and 'centre'. Accordingly the Review Team determined the area under review to be theatres, the cardiac intensive care unit and, to a lesser degree, the cardiothoracic ward. Reference to the 'unit' throughout the report is the collective for these areas.

In addition the period of review in relation to issues raised is stated as 'spring 2010 to date' within the terms of reference. The Review Team have therefore reviewed, considered and made appropriate reference to information provided up to the issue of this report.

This review was conducted to establish the veracity of the immediate concerns regarding patient safety, staffing levels and managerial responses to concerns raised. In the opinion of the Review Team it was also essential to identify the risks and barriers that may compromise the development of a sustainable safe service at the OHC.

Opinion:

In our opinion there is no evidence that the complaint concerning unsafe practices is substantiated. It has however provided an opportunity to independently investigate the unit through staff feedback and data analysis, which in itself has been useful for highlighting areas of improvement in relation to the functioning of the unit.

This is however a highly pressurised environment in which to work and accordingly will result in stressful situations from time to time, which may have a negative impact of some staff members. Several senior nurses in the Directorate and the surgeons are carrying a stressful burden and this was expressed to us.

There have been a number of reviews of the unit over the last few years and many of the staff are fatigued by the process. The apparent lack of implementation of previous recommendations to improve the culture and deal with behavioural issues in the surgical unit, continues to inhibit its smooth function and future stability.

There is still a lack of leadership, trust and cohesiveness in the Directorate to enable good team dynamics to prevail.

The staffing numbers, when taking into consideration the use of locum and agency members of staff, for all relevant staffing groups are satisfactory. This does not detract from the fact that there have been issues recruiting and that pressure has been placed on existing staff. In addition the current, albeit temporary situation, in relation to key members of the Divisional management team, mean there is a gap between strategic and operational management, which may result in additional pressure for current staff.

We found that members of staff were generally aware of the systems and processes within the Trust to raise issues and concerns. Whilst we appreciate that for some individuals the responses they received may not have been as they wished this is down to differing professional opinions rather than a failure to address. The problems around these areas stem from the cultural issues and in some cases failure to work effectively as a team although there is a need for central co-ordination of responses to ensure members of staff are always aware of action taken.

We believe that for this review to stand out from the others the methodology for feeding back to staff, thanking them for their participation and keeping them apprised of actions going forward is a key factor.

Professor John Wallwork
Lead Reviewer

1. Introduction

- 1.1 In March 2013 the Chief Executive of Oxford University Hospitals NHS Trust ('the Trust') commissioned an independent review of cardiac theatres and the wider cardiac surgical unit as appropriate, with the focus on staffing; both levels and competency, and their potential impact on patient safety. This was triggered by issues raised internally by staff and an anonymous complaint to the Care Quality Commission (CQC).
- 1.2 To undertake this review the Chief Executive set up an independent review team, comprising:
- Professor John Wallwork, retired Consultant Cardiac Surgeon; Papworth Hospital NHS Trust
 - Steve Livesey, Consultant Cardiac Surgeon; Southampton NHS Trust
 - Sue Langley, Head of Nursing, Division of Specialist Medical Services; Central Manchester Foundation Trust
 - Lisa Locker, Cardiothoracic Matron; Sheffield NHS Trust
 - Susan Stoker, Independent Management Consultant (Governance)
- 1.3 It is understood that leading up to the review there was significant communication with staff across the Directorate. We have been informed that this communication took the form of both written and verbal, including the holding of open briefing sessions with cardiac unit staff to explain how the process would work and to encourage open and honest participation.

2. Background

- 2.1 Oxford University Hospitals NHS Trust, one of the largest NHS teaching trusts in the UK, employs approximately 11,000 members of staff over the four hospital sites; John Radcliffe Hospital, Churchill Hospital and Nuffield Orthopaedic Centre, all located in Oxford, and the Horton General Hospital in the north of Oxfordshire. The Trust has a number of key collaborations including with the University of Oxford, Oxford Biomedical Research Centre and the National Institute for Health Research. The Trust is currently working towards becoming a Foundation Trust.
- 2.2 The core values of the Trust are excellence, compassion, respect, delivery, learning and improvement. These values determine the Trust's vision, which is to be at *'the heart of a sustainable and outstanding, innovative, academic health science system, working in partnership and through networks locally, nationally and internationally to deliver and develop excellence and value in patient care, teaching and research within a culture of compassion and integrity.'* The Trust has a number of aims that underpin the vision, including the encouragement of a spirit of support,

respect and teamwork and ensuring that they act with integrity. The Trust identifies that its staff are central to the vision.

- 2.3 The Trust provides a wide range of clinical services, specialist services which include cardiac, medical education, training and research. The delivery of the services is through a clinically led structure comprising seven clinical services reporting into the Director of Clinical Services. Each clinical service is managed by a medical qualified Divisional Director, with accountability to the Director of Clinical Services for the day-to-day management, delivery and governance. The Divisional Director is supported by a General Manager, Clinical Directors and senior nursing staff. Divisions have their own finance and human resources business managers, and dedicated clinical governance resource. All Divisional Directors are part of the Trust Management Executive, an executive management decision-making body for the Trust.
- 2.4 The Trust includes the Oxford Heart Centre, situated at the John Radcliffe Hospital in Oxford, which undertakes adult cardiac surgery and takes patients from a number of counties including Oxfordshire, Northamptonshire, Gloucestershire and Berkshire.
- 2.5 Cardiac surgery within the Trust is part of the Cardiac, Vascular and Thoracic Surgery Directorate; this directorate being one of two directorates within the Division of Cardiac, Vascular and Thoracic. A structure diagram for this Division is provided in Appendix 1.
- 2.6 The Oxford Heart Centre has been subject to a number of reviews, both general and specific, in recent years, including by Healthcare Commission in 2007 and the Strategic Health Authority in 2010. These reviews have raised concern about the functioning of the cardiac surgery unit, including leadership and the ability to work effectively as a team and for the good of the service. It is understood that some actions were taken by the Trust, as a result of previous reviews, in an attempt to improve working relationships in the cardiac surgical service.

3. Review

Objective:

- 3.1 The objective of the independent review, as defined by the Trust, was to conduct an investigation which delivers independent scrutiny to Oxford University Hospitals NHS Trust cardiac theatres and provide a report that:
1. Identifies and addressed any relevant concerns arising during the review, in relation to patient safety and staffing within cardiac theatres;
 2. To investigate and comment upon Oxford University Hospitals NHS Trust's response to identified issues regarding patient safety and/or staffing within cardiac theatres, with specific regard to the scope, adequacy and effectiveness of that response.

Terms of Reference:

3.2 The terms of reference of the review, as defined by the Trust, were:

1. To consider concerns about the cardiac theatres service, with specific reference to issues of patient safety and staffing;
2. To identify any objective evidence of patient safety concerns within the unit, considering outcomes data, case mix, skills mix and any specific concerns raised by staff at interviews;
3. To identify what an appropriate staff mix and numbers would be for the unit, and to compare that benchmark with current levels of staffing, to establish whether the staffing is fit for purpose based on the unit capacity and acuity;
4. To specifically establish whether there is a lack of expertise and trained staff to undertake procedures and provide suitable support in cardiac theatres;
5. To consider the team dynamics within the cardiac centre, including the culture within the team, and to identify whether it impacts in any way upon patient safety or the performance of the service;
6. To explore how and when concerns have been raised by members of the cardiac centre team, and to comment upon the ease or difficulty with which staff in the unit raise concerns;
7. To critically assess the response to any patient safety concerns raised by cardiac centre staff, in terms of effectiveness of any action taken by the management team, to investigate and address the concerns;
8. To make recommendations for the consideration of the Chief Executive and Medical Director of the Hospital as to: -
 - a. Whether there is a basis for patient safety concerns about the cardiac theatres service in light of the findings of the review
 - b. Whether there is a basis for staffing level concerns within the cardiac theatres service in light of the findings of the review
 - c. Possible courses of action which may be taken to address any specific areas of concern which have been identified

Scope:

3.3 The terms of reference of the review, as defined by the Trust, make reference to 'unit', 'service' and 'centre'. We have taken these terms to be interchangeable and have determined the 'unit' to include theatres, cardiac intensive care unit and, to a lesser degree, the cardiothoracic ward. Accordingly we considered all of these areas to be within the scope of this review.

3.4 In addition the objective within the terms of reference provided a timeframe for the review of issues being raised as 'since spring 2010 to date'. The Review Team has

taken the 'to date' to mean the point at which the report is finalised. This timeframe has been applied wherever relevant throughout the review. We believe that in order to provide an objective and fair assessment there is a duty to consider all information made available until the finalisation of the report.

- 3.5 Although strategic issues pertaining to the cardiac unit were not specially detailed within the terms of reference it is our belief that safety and sustainability are intrinsically linked. We have therefore considered the issue of the development of the unit during this review.

Limitations of Scope:

- 3.6 We have been made aware of further work undertaken in relation to theatres at the trust; however, we have not had access to the draft report arising from this. We are therefore unable to comment at this point whether this report would impact on our findings, conclusions and recommendations.

Methodology:

- 3.7 The following methodology refers to that utilised by the Review Team and does not reflect additional work the Trust may have undertaken as part of the preparation for this review.
- 3.8 The Review Team worked together to undertake a number of pieces of work within the review; interviewing members of staff, reviewing statistics in terms of clinical procedures, reviewing statistics in terms of staffing and reviewing documentation.

Interviewing members of staff

- 3.9 The Review Team, or part thereof, visited the Trust as a team on three different occasions to interview staff. The dates of these visits are noted below:
- Monday 13th May to Wednesday 15th May 2013 inclusive
 - Wednesday 19th June to Thursday 20th June 2013 inclusive
 - Friday 5th July 2013
- 3.10 The selection of members of staff to be interviewed was made at random by the Lead Reviewer. In addition the message was given by the Review Team that they were willing to see anyone who wanted to be interviewed. A number of the individuals interviewed during the second and third visit were those who had made such a request; in some cases this was a second interview.
- 3.11 The detail of members of staff interviewed is provided in Appendix 2. Approximately 25% of members of staff from the areas considered to be within scope were interviewed.

Review of data in terms of clinical procedures and staffing

3.12 Documentation provided by the Trust and generally available statistics were reviewed prior to the commencement of the review and at key points throughout.

Review of documentation

3.13 Documentation was provided prior to the start of the review and at numerous times throughout the duration of the review. This was reviewed by team members and the results of the analysis are referred to where relevant throughout this report. The detail of documentation reviewed is provided in Appendix 3.

Identification of Findings

3.14 Our findings are based on the professional judgement of the Review Team and evidence reviewed, which can be in the form of documentation or triangulation of information including interviews.

4. Findings

We have reported our findings under the individual headings within the terms of reference.

To consider concerns about the cardiac theatres service, with specific reference to issues of patient safety and staffing

- 4.1 We found that there was no evidence, from our review of clinical outcome data, clinical incidents and interviews undertaken with staff, to suggest that patient safety was imminently at risk. That is not to say that there were not issues that could be improved and real concerns about some aspects of the unit's function.
- 4.2 All interviewees were asked during their interview, usually at the outset, two specific questions, around but not restricted to the following wording:
- 1 Did they understand the purpose of this review?
 2. Did they think that the Oxford Heart Centre was unsafe for patient care?
- 4.3 None of the staff responded that they thought that the care of surgical patients in the Oxford Heart Centre was unsafe. However many commented that the unit could do better and expressed their concerns, particularly around staffing levels and recruitment in the theatres and the CTCCU.
- 4.4 The majority felt that the direction and pace of travel towards fully recruiting, training and educating established staff had improved since the beginning of 2013 and during the period of this review in particular a lead SCP had been appointed along with other colleagues and trainees.
- 4.5 We felt that many of the problems both historical and current within the Oxford Heart Centre stemmed from a lack of effective surgical leadership within the Directorate, through the Division.
- 4.6 Detailed findings in relation to patient safety and staffing are provided in the sections below.

To identify any objective evidence of patient safety concerns within the unit, considering outcomes data, case mix and any specific concerns raised by staff at interview

- 4.7 There were reports from staff of diverse individual practices within the surgical teams related to use for instance of theatres disposables, sutures, and valves. However there is some progress towards set standards for all procedures, although this was not a consistent message across all staff groups with the surgeons themselves confirming the lack of defined and agreed protocols.
- 4.8 Compliance with the WHO checklist was reported by the nursing staff although it was reported there was still some non-attendance by surgeons at the de-brief meeting. Review of both Divisional and Directorate papers revealed WHO compliance as 'remaining an issue, particularly in CTVS' (quote taken from the minutes of Divisional Executive Meeting).
- 4.9 Most of the nursing staff interviewed highlighted concerns about the on call arrangements and the reduction in sleep time. It is understood that although the Trust Policy found on the Intranet refers to 11 hours, the 'local' policy within cardiac theatres is 8 hours plus half an hour for travelling. From the scrub nurses it was reported staff were undertaking up to three on calls per week and the reduction in sleep time with a heavy on call commitment caused concern. The scrub nurses felt they had raised this issue with their immediate management team however the scrub nurses thought that this was a Trust-wide implemented practice and therefore little could be done. On review of documentation provided by the Trust in relation to the working time directive it was noted that the requirement is 11 hours for non-medical staff. We have not seen any local policy.
- 4.10 Supporting documentation provided by the Trust was used to ascertain the veracity of these concerns. However in some cases, despite the absence of supporting evidence, the information could be triangulated via the consistent message from a number of individuals.

To identify what an appropriate staff mix and numbers would be for the unit, and compare that benchmark with the current levels of staffing to establish whether the staffing is fit for purpose based on the unit capacity and acuity

4.11 We reviewed all staffing groups in terms of numbers and skills mix using data provided to us by the Trust and national guidance where appropriate. We reviewed staffing levels in general and specifically the staffing in theatres relating to SCPs and Perfusionists as these were the areas of greatest concern expressed by to us.

SCPs / Perfusionists

4.12 Although the SCP and the perfusion service relied heavily on locums until recent appointments had been made we were reliably informed and confirmed, that the locums who had been employed were properly qualified and vetted for their posts. From the risk registers reviewed, (Divisional for 2012/13 and Directorate as at July 2013) it was noted that the risk in relation to failing to meet N+1 standards for perfusionist staffing was noted during 2012/13 at Divisional level, together with proposed solutions and remains on what was entitled the '*Cardiac, Thoracic & Vascular Surgery Directorate Risk Register up to July 2013*' as an amber risk despite 'positive progress on recruitment' (quote taken from Directorate Risk Register).

4.13 The locums also had a period of induction on their first experience of the Oxford Heart Centre. The impression that there were a continuing flow of new individuals in these locum posts was not substantiated in that many of the locums worked on a regular basis and were familiar both with the theatre and the personnel within them at Oxford.

4.14 Every attempt was made to cover the operating sessions both with numbers and the appropriate skill mix but we accept that inevitably this would occasionally break down through lack of staff and inappropriate skill mix in the team for highly complex cases. On occasion cases had to be cancelled for these reasons that is based on clinical safety grounds. What constitutes safe practice in relation to the level of staffing available for any particular operating session is a matter of professional opinion and judgement and is relative to the clinical risks associated with individual patients.

Surgeons

4.15 The unit has four full time active surgeons and has just appointed a fifth. There are two full time thoracic surgeons. There are nine support surgeons, five trust fellows, three national training number [NTN] trainees and one thoracic surgical trainee.

4.16 The staffing levels are appropriate for the surgical workload assuming the normal activity per cardiac surgeon nationally is of the order of 200 cases per year.

4.17 There are no current issues with outcome measures monitored by both Dr Foster and the Society of Cardiothoracic Surgeons on behalf of NHS England.

Cardiac Theatres Nursing

4.18 We believe that the current provision of nursing staff within cardiac theatres to be appropriate in terms of numbers of whole time equivalents (WTE) and the provision of staff per theatre. The nursing metric information shows cardiac theatre nursing staffing has been at 100% for the period November 2012 to April 2013.

- 4.19 It is difficult to provide direct comparisons with other theatre units as the case mix may vary from unit to unit, for example for some cardiac units their theatres are part of general theatres, for some units there is a thoracic cardiac case mix, for others thoracic, cardiac and transplant and for Oxford the case mix is cardiac, thoracic and vascular.
- 4.20 There has been a concern about vacancy rates and the resulting use of agency staff. This, however, appears to have been mitigated by ensuring regular agency staff were temporarily attached to lines of work on the nursing rota. Skill mix was raised as a concern but there appears to be on-going work to improve skills in this specialist field and develop staff to their full potential. We noted from the interviews that at times there does appear to be a heavy reliance on existing staff covering shortfalls in rota cover.
- 4.21 Whilst on some occasions the circulating nurse had to cover two theatres generally theatre staffing was safe. Staffing levels were compliant with the national criteria of two scrub nurses and a circulating nurse per theatre the majority of the time.
- 4.22 Concerns in relation to sickness levels amongst the scrub nurses were voiced. On review of the latest sickness levels for nursing (excluding Clinical Support Workers) it was noted that the scrub side was only slightly higher than the Trust's aim of 3%. The perception from staff was that the scrub side had a greater sickness problem. This could be because within a small team individual absence may be more noticeable.
- 4.23 No nursing staffing issues were highlighted from anaesthetic side. General feedback from the interviews appeared to indicate a more stable team position.
- 4.24 The local cost of living was frequently cited as a reason for difficulty with recruitment and as a potential reason for turnover within nursing. It was highlighted that, as with other staff groups, staff could live in Oxford, travel to London to work in the London area and receive the additional London weighting allowance. We understand that this is a problem across the Trust and not specific to the cardiac unit.

Cardiac Thoracic Critical Care Unit (CTCCU) Nursing Staffing

- 4.25 It is difficult to provide a direct comparison with other units as again the case mix for units can vary; not all units have combined surgical intensive care with coronary care, and the unit footprint can affect staffing.
- 4.26 We believe that the current provision of staff to be appropriate for the number of beds according to national guidance. The staffing numbers on CTCCU and theatres appear, on the information provided to the Review Team, to meet with national bench marking and follow staffing guidelines set by the Intensive Care Society. There needs to be an assurance that on a 'shift by shift' basis the patient dependency on CTCCU is assessed and the correct number of nurses are on duty with the appropriate skill set in place to deliver safe care to all. This is a matter of professional judgement and as such has not been subject to assessment by the Review Team.

- 4.27 as within theatres there were concerns raised about skill mix, particularly in terms of critical care cardiac surgery skills as opposed to CCU skills and this was linked to the joining of the two areas. There had been a difficult period for staffing when the two units first joined together and some experienced cardiac surgery nursing staff, including Band 7 nurses, left as there was a greater requirement to be rostered onto night shifts being that the unit is aiming for 24/7 Band 7 coverage. One of the surgeons highlighted that several skilled cardiac surgery Band 7 nurses had left the Trust when the units amalgamated.
- 4.28 There was a strong view held by one surgeon that there was a lack of surgery skills in cardiac critical care surgery skills, which had impacted on patient safety. Other interviewees, nurses, anaesthetists and surgeons, noted this surgeon's strongly held view about the lack of cardiac critical care surgical skills but did not believe this to be the case.
- 4.29 Some surgeons also felt the unit's nursing leadership was too cardiology focused as the Lead Nurse has a cardiology background and this contributed to the lack of specific surgical nursing skills cardiac critical care.
- 4.30 We have seen from a limited staff survey one year after amalgamation, responses from about a quarter of the nursing staff and two medical staff, that there were some issues with training and morale although in general there are positive responses in most areas of the survey which covered job satisfaction, training, feeling of integration and impact on nursing care.
- 4.31 It was reported from the interviews that patients' safety in relation to correct staffing was always adhered to and in the unfortunate circumstances when safe staffing levels could not be met patient surgery was cancelled. However the Lead Nurse would always ensure every avenue had been explored in relation to staffing a CTCCU bed before cancelling a patient.
- 4.32 Senior nursing staff have been subject to consistent high degrees of critical challenge in relation to staffing, particularly the cardiac surgery skill mix compared to the cardiology skill mix, from surgeons and anaesthetists. These issues have required the support for the unit senior nurses from the Deputy Chief Nurse, with the unit's senior nurses feeling well supported in this way. Relations between the Anaesthetic Lead and Nursing Lead are reported as supportive and productive. We believe the CTCCU to have sufficient numbers of nurses with a specialist qualification in critical care.
- 4.33 There was evidence of good patient feedback (CTCCU Patient Questionnaire April 2013) but this was limited to the feedback of a small number of patients. There have been four complaints attributed to CTCCU in the last year with one complaint related to post-surgical care.

To specially establish whether there is a lack of expertise and trained staff to undertake procedures and provide suitable support in cardiac theatres

4.34 In our opinion there are a number of issues to be taken into account when considering the level of expertise and skilled staff available for cardiac theatres, including the structure of the Directorate. These are reflected below in our findings.

Surgeons, Anaesthetists, Intensivists and Nursing Staff

4.35 The inclusion of vascular surgery in this Directorate and Divisional structure may seem to have some managerial logic. However in this particular instance it is an added distraction to an already stretched Division.

4.36 Combining cardiology and cardiac surgery makes sense and creates the opportunity to share skills across the specialities which are increasingly performing an integrated repertoire of combined operations and procedures. The increasing age and co-morbidity of the patients they treat supports the development of a specialised CTCCU.

4.37 This clearly has not been an easy marriage to arrange and manage, particular in relationship to the skill mix in theatres and CTCCU with staff coming from diverse backgrounds.

4.38 We saw and heard evidence that there are structures in place to address these areas, particularly targeted toward education and training in the CTCCU and the introduction of a theatre manager brings some leadership structure in the theatre area.

4.39 Anaesthesia and intensive care provision has undergone radical change with the appointment of a full-time director of intensive care and the restructuring of roles within CTCCU and theatres. This has caused some tensions particularly among consultant anaesthetists but there is no evidence that these changes have had a negative impact on patient safety.

4.40 The evidence from the interviews with scrub nurses is that there is a cohort of skilled and experienced cardiac surgery scrub nurses, however this is a stretched resource particularly in terms of on call cover and staff working in their holidays.

4.41 Lines of agency nurses were utilised and from a nursing view point they were sufficiently skilled for cardiac surgery scrub nurse roles.

4.42 Two surgeons highlighted that they were often unaware of who they were working with in terms of scrub nurses and this they thought this was a safety concern. This clearly emphasises the importance of implementing the WHO safety checklist. Other surgeons did not echo this concern. The scrub nurses reported that they risk assessed less experienced scrub nurses to scrub for less complex patients.

4.43 Appraisals take place with good rates of compliance (monitored via management reports). It was noted, however, that up-to-date job plans were not in existence for all surgeons. One job plan was at least two years out-of-date and still included reference to paediatric surgery.

- 4.44 From the data provided on statutory and mandatory training (relating to cardiac and thoracic theatres), it could be seen that anaesthetic nursing are above the Trust aim of 95%. However the surgical nursing group is much lower at 73.5%, with a number of low compliances in certain medicines management, transfusion and Venous Thromboembolism (VTE) across different staffing groups. The recently introduced educator role has initially concentrated on mandatory training compliance.
- 4.45 Senior nurses in theatre find it difficult to balance the managerial and clinical leadership aspects of their role. We noted that there are plans for the introduction of a theatre manager role, which may alleviate this issue. It is noted the Matron is visible within the theatre setting but does not have a “clinical day” within theatres for example spending time working alongside staff. Generally there was a concern that the co-ordinator role was inconsistent in its effectiveness and this was sometimes due to staffing problems.
- 4.46 The Matron and Divisional Nurse were noted to attend fairly regularly at the theatre meetings chaired by the theatre lead surgeon; the Band 7 theatre nurses also attended this meeting.
- 4.47 It was noted that the anaesthetic and scrub nursing are kept operationally separate. In our opinion this is a dated approach as most other U.K. centres have a combined team that are able to undertake both sides, giving the team more options in skill mix and staffing.

Surgical Care Practitioners (SCP)

- 4.48 The role of the Surgical Care Practitioner was developed at the cardiac unit, John Radcliffe Hospital and it has to be acknowledged that this was a ground breaking role and there are still members of staff within the unit who progressed this role. There has however been a number of difficulties with recruiting in to these roles in recent years, which has obviously has an impact on both staffing numbers and the expertise/support available within the cardiac theatres.
- 4.49 The current establishment for SCPs is nine WTE, although one of these is on a zero hours contract. The establishment consists of a Band 8a lead role which we understand has been recruited to, three Band 8a practice development roles that have start dates of September 2013, two Band 7s (including one with zero hours contract) and three Band 6 trainee roles that are filled. The structure has been one that has evolved to build a team including trainees. The higher grading reflects the work undertaken by the Trust to attract staff to Oxford.
- 4.50 In the past recruitment of qualified full time SCPs was thwarted by alleged external influence on an appointed candidate who did not take up the post of lead SCP.
- 4.51 There was a strong theme concerning the lack of SCP support for the cardiac surgery programme and problems it caused through a heavy reliance on junior doctors. Senior staff reported concerns to the senior management team but it is only recently that the establishment and banding of the SCP has been effectively addressed. In order to mitigate the risk of a reduced SCP workforce, regular agency staff have been employed from other units within the country.

- 4.52 As already noted the SCP perfusion service relied heavily on locums until recent appointments had been made. The need for such a service may continue in the short term whilst recruitment continues however as we were reliably informed and confirmed, that the locums who had been employed were properly qualified and vetted for their posts we see no problem with this method of working.
- 4.53 We noted from the interviewees the concern that, along with prohibitive cost of living locally and the level of banding of the posts, initially set at band 6; the reason for the lack of success in recruitment was related to the reputation of the unit and the behaviour of surgeons deterring potential new SCPs to the role.
- 4.54 In general the feedback from the interviews highlights the positive approach currently being taken to recruitment and banding changes.

Clinical Support Workers

- 4.55 We were informed that the Clinical Support Workers did not have documented evidence of competency training, in part because the training is not always available and in part because when it is, there is no formal competency package. This has resulted in dissatisfaction with the level of training available. We understand that there is an Induction Programme for Clinical Support Workers, however this does not address on-going competency training for this staffing group.

To consider the team dynamics within the cardiac centre, including the culture within the team, and to identify whether it impacts in any way upon patient safety or the performance of the service

- 4.56 As would be expected for unit such as cardiac both team dynamics and culture are at various levels and within different groups. We have addressed this by looking at this from different perspectives.

The Divisional Structure

- 4.57 The concept of the divisional structure to empower those delivering service is a sound one in principle.
- 4.58 However in this instance the inclusion of vascular surgery with cardiology and cardiac surgery does not fit well. Although there is some commonality in that both specialties treat disease of blood vessel, in practice the two surgical specialties are very different and have very little in common. As a consequence of the absence of effective senior cardiac surgical leadership when the Division was established, its leadership was skewed towards cardiology.
- 4.59 The only effective cardiac surgical input into the structure was from a highly competent but managerially inexperienced surgeon and there is evidence that his authority was and continues to be undermined by his surgical colleagues.
- 4.60 The Divisional Director, his deputy and the General Manager have been aware of the perception that cardiology interests prevail and tried to redress this imbalance, but this has not been easy in the environment in which they have had to work and has reinforced the perceived lack of input to the Division by cardiac surgery.

- 4.61 The authority and function of the Division in the current circumstances is further weakened by having an Interim Director, from none of the specialties it represents and for whom this is an additional role having responsibility for his own Division (Neurosciences, Trauma & Specialist Surgery). In addition the Divisional Nurse role is currently vacant, which, although covered in the interim by Matrons, potential leaves a gap between operational and strategic responsibilities in relation to nursing within the Division. Whilst it is accepted that both of these interim situations have only occurred recently the current situation makes effective team-working and team-building more difficult and puts members of staff under additional pressure.
- 4.62 The lead surgeon in the Directorate being a vascular surgeon was felt by the cardiac surgeons not to understand the issues relating to their specialty and as a consequence did not hold their confidence.
- 4.63 In addition, as the Division has been expected to manage the above issues within the Division, the Trust's senior management has not always been aware of the magnitude of the issues presented by the cardiac surgery group.

Engagement of the Surgeons

- 4.64 The vacuum of effective surgical leadership in the Oxford Heart Centre, which began before the new divisional structure was put in place, is chronic and complex, despite the good work of a number of individuals who are working in difficult situations. This needs to be addressed.
- 4.65 There has been an abrogation of leadership roles in the challenging and changing landscape of the NHS via the senior surgeons.
- 4.66 The senior surgeons particularly expressed, on several occasions that they felt 'marginalised and isolated' from decision making.
- 4.67 Past conflict and an apparent reluctance or inability to engage in the necessary changes in the NHS have further inhibited effective participation the running of the service.
- 4.68 There is an 'us and them' mentality and a disdain for management which is unhelpful.
- 4.69 There is a danger that these attitudes and behaviour patterns will be adopted by more recently appointed colleagues. These consultants did not have formal mentors.
- 4.70 There appears to be a lack of insight on the effect of 'off the cuff' remarks, in particular by the surgeons, have on other staff.
- 4.71 We heard evidence from various sources of persistent and corrosive harassment at a personal and professional level. This can be subtle and any one event may seem trivial but taken as a whole it can be destructive and saps energy that should be directed elsewhere. Individual senior nursing staff do appear to have been subject to consistent high degrees of critical challenge in relation to staffing from individual surgeons which required robust senior management support.

4.72 The reality is that for whatever reason relationships are strained. This makes the Directorate (and particularly the cardiac surgical group) at times extremely difficult to manage and puts at risk the delivery of the outline business case and the future sustainability of the service.

Team Working

4.73 Some of the surgeons had stated “that they had never been more united than they are now” and are working better together than they have previously. This is an aspiration to be encouraged.

4.74 However there is some way to go for this team to function effectively. We heard that too often the surgeons were pursuing their own individual agendas rather than those of the entire team and there is evidence of continued friction among the surgeons.

4.75 Waiting lists are skewed. Cardiological referral practices for routine cases both within the trust and the network it serves are not evenly distributed between the individual surgeons. Some surgeons effectively having no waiting list and rely on in house urgent cases.

4.76 The current clinical lead for cardiac surgery is not supported by his colleagues as he should be and thus plays a less effective role in an already under-represented area in the Directorate.

4.77 Inclusion in management of a further colleague in a leadership role in theatre has the potential to improve but not entirely correct this imbalance.

4.78 At various times leaders of the Division felt that they were less than well supported by corporate management.

4.79 We were informed that there have been times when the Division was expected to deal with issues which under the current situation that they felt they neither had the authority or skills to do. In such circumstances corporate management did not take sufficient support, leadership and responsibility to resolve these problems in a timely manner.

4.80 Previous reviews have made mention of concerns around the functioning of the cardiac unit and the ability to work effectively as a team and for the good of the service. Whilst reference was made to the old style of working still being prevalent a number of members of staff interviewed stated that these areas have improved over recent years and were keen to show their support for groups of staff and individuals. This is encouraging to note.

4.81 However we were made aware of behaviours and ways of working that clearly show this still to be an issue, despite great efforts on the behalf of some individuals. In our opinion the Trust’s value of respect and aim of teamwork are not reflected within certain areas of the unit. Effective teamwork is key to the on-going development of this service, as identified in the OBC as a risk to its implementation and thus the sustainability of a safe and functioning unit.

- 4.82 Where units are able and/or willing to work outside the boundaries of governance systems, for example by failing to have defined and agreed protocols, there are inherent safety issues. Whilst we saw no evidence of negative impact on patient safety as a result of such working this is likely to be due to individual ability rather than a structured approach. It is our opinion that in order for any unit to function safely and effectively a degree of uniformity and team working is required.
- 4.83 The use of common and agreed protocols enables junior medical and nursing staff to deal with frequency occurring events, providing confidence that such situations are being dealt with in an appropriate manner therefore increasing patient safety and the job satisfaction of such staff.
- 4.84 There was a concern that theatre nursing staff meetings had recently declined in frequency originally they were held on a monthly basis but interviewees stated more frequent meetings to promote better communication could be helpful. In relation to wider communication throughout the Trust it was noted that many nursing staff were unaware of Trust-level initiatives and briefings. We accept that the nature of their work allows limited time for involvement in Chief Executive or senior management briefings, however feel that such engagement would strengthen the sense of belonging, and reduce the view that 'the Trust' as a separate entity, rather than being an integral part of whole .
- 4.85 There has been a legacy of corrosive professional politics and an 'us and them' attitude, particularly relating to management.
- 4.86 From the interviews it was noted that nurses did not raise any specific issues of poor inter nursing team-work. The nursing staff are engaged and motivated.
- 4.87 It was reported that there is a good working relationship between anaesthetists and surgeons in general.
- 4.88 There was universal support amongst the members of staff who referred to the 'Human Factors' training. This training is especially designed to strengthen teams working in high pressure environments and its use reflects a positive approach to development of the unit. It was noted from a review of the attendance list for this training that not all members of staff who would reasonably be expected to attend had taken part in this training.

To explore how and when concerns have been raised by members of the cardiac centre team, and to comment upon the ease or difficulty with which staff in the unit raise concerns

- 4.89 We were reliability informed that no formal concerns were raised under the *Raising Concerns Policy* by staff from cardiac theatres during the period under review, April 2010 onwards. On further investigation we ascertained that this is also the case for CTCCU for 2011/12 and 2012/13. In light of this information we concentrated on the documentation provided to us by the Trust, such as letters and emails, to ascertain how concerns have been raised. This information related to a recent period. Individuals also provided us with documentation going back over a more prolonged timeframe.

- 4.90 From the interviews we ascertained that generally members of staff are aware of the systems for raising concerns, such as the Incident Reporting System. In addition there was a view amongst nursing staff that divisional management were open and accessible in such situations.
- 4.91 In relation to issues raised during the period December 2012 to March 2013 (documentation provided by the Trust) we noted that in the main the route of report was reasonable and whilst not always following the direct line reports, could be understood.
- 4.92 We are aware of a couple of cases where the individuals involved were not satisfied with the response. In one case where the issue had been raised via an informal route in that it had not been under the *Raising Concerns Policy*, a response was not received until sometime later. It is understood that the response has now been received. In the other case, the investigation of an incident, it was felt that feedback in terms of going through the incident report had taken too long. In our opinion the Trust had dealt with this issue correctly.
- 4.93 We reviewed the list of cardiac incidents for the period 1st April 2012 to 30th June 2013 as provided by the Trust. There were a total of 111 incidents on this list showing that incidents are reported. It is difficult to say whether this is the norm, or an outlier, when compared against other organisations as all are different in terms of the size of directorates and clinical services units.

To critically assess the responses to any patient safety concerns raised by the cardiac centre staff, in terms of effectiveness of any action taken by management team to investigate and address the concerns

- 4.94 By virtue of the fact that the Trust commissioned this review it has responded in an open and transparent way to the latest issues raised. We have also seen evidence of action taken in relation to recruitment of SCPs, in the re-banding etc. Both of these are considered by the Review Team to be appropriate responses. The recruitment of SCPs has taken some time to address, a point that was acknowledged by Trust senior management, however positive action is now underway.
- 4.95 In a number of cases the responses we have seen show that concerns raised have been acknowledged and that the outcome is due to the difference of a professional opinion rather than inaction.
- 4.96 The senior surgeons particularly commented that issues they raised were not dealt with in a timely manner or not at all. We have seen email correspondence to some of their concerns and reference to verbal responses for the majority. Where the Review Team has seen responses they were noted to be, in the main, timely. Action noted to be taken was considered to be relevant.
- 4.97 We have been unable to match all correspondence with a reply from the documentation provided to us. Accordingly we are unable to ascertain what action has been taken in all cases. However, as the concerns raised were related to patient safety and staffing issues, the work undertaken in relation to this review has

shown these areas are not currently of concern and accordingly the allegations raised have not been substantiated.

5. Recommendations

We have made our recommendations under the headings from the terms of reference, together with a final heading in relation to the strategic issues currently facing the Division in relation to the cardiac unit.

Recommendations to address concerns about the cardiac theatres service, with specific reference to issues of patient safety and staffing

- 5.1 The Trust Board of Directors should continue to follow good practice and, using current governance systems, review patient safety and staffing issues in relation to the cardiac unit.

Recommendations to ensure continued patient safety within the unit and to address specific concerns raised by staff at interview

- 5.2 The Trust Board of Directors should seek assurance from the interim Divisional Director that all relevant Trust Policies are being followed at Divisional level.
- 5.3 The interim Divisional Director should facilitate the completion of defined and agreed protocols. Common protocols need to be agreed and implemented for the vast majority of routine patient care, taking good practice from other units.
- 5.4 The interim Divisional Director should review current compliance with WHO checklist and, working the Clinical Director and lead for theatres agree an action to ensure 100% compliance.

Recommendations to ensure there remains an appropriate staff mix and numbers in the unit and that the staffing is fit for purpose based on the unit capacity and acuity into the future

- 5.5 The Trust Board of Directors should seek assurance on a regular basis, using current governance practices and those development in response to the Francis Report and potential changes in the CQC approach, to ensure that appropriate skill mix and numbers exist within the cardiac unit in relation to capacity and acuity.
- 5.6 Consideration should be given to the assurance mechanisms required in relation to the 'shift by shift' basis assessment of patient dependency on CTCCU.
- 5.7 Consideration should be given by the Divisional Nurse to ensuring a more equal balance of cardiothoracic/cardiology nursing leadership.
- 5.8 A further evaluation of stakeholders in relation to CTCCU should be undertaken.

Recommendations to address issues in relation to maintaining the correct level of expertise and trained staff to undertake procedures and provide suitable support in cardiac theatres

- 5.9 The Trust Board of Directors should consider removing vascular surgery to its own or another directorate.
- 5.10 The Clinical Director (Cardiac, Vascular & Thoracic Surgery) should ensure that there are up-to-date job plans and annual appraisals all surgeons.
- 5.11 The Trust Board of Directors should continue to review statutory and mandatory training compliance for the Division and Directorate to ensure compliance with the Trust standard of 95% on an ongoing basis.
- 5.12 The Clinical Director (Cardiac, Vascular & Thoracic Surgery) should review statutory and mandatory training at staff group level and liaise with professional leads for these groups to ensure high level of compliance for all subjects and at all levels.
- 5.13 The Matron/Lead Nurse should spend time working in the clinical areas they manage alongside frontline clinical staff, for example three days per month working a clinical shift in theatre. This would give visibility to the surgeons regarding the senior nursing team and greater informal communication links for their nursing staff.
- 5.14 The Matron/Lead Nurse should develop a comprehensive skills matrix for CTCCU and Cardiac theatres in order to ensure robust skills development in these specialist fields alongside mandatory training requirements.
- 5.15 The Matron/Lead Nurse should plan to ensure regular nursing staff meetings within cardiac theatres as well as the theatre users group to promote good communication within the theatre nursing team.
- 5.16 Greater consideration needs to be given to the theatre team and having a much more modern approach to the theatre work with scrub and anaesthetic practitioners being able to work in both specialities allowing a much more flexible approach to staffing theatres safely.
- 5.17 Formal competency packages for theatre and CTCCU, including for Clinical Support Workers, should be developed to address not only issues of safe practice but also concerns about knowledge and skills raised by consultant bodies.
- 5.18 Succession planning should be in place for senior consultants and surgeons, to avoid lack of expert service provision and to enable future planning.
- 5.19 Formal mentorship should be in place particularly for new consultants.

Recommendations to address issues of team dynamics within the cardiac centre, including the culture within the team

- 5.20 The Trust Board of Directors should give consideration to how the Division and Directorate is strengthened and proposed changes to personnel in posts for November 2013 brought forward.
- 5.21 Consideration should be given to recruiting, externally, a senior lead cardiac surgeon.
- 5.22 The Director of Clinical Services should give consideration to how leadership roles and responsibilities within the Division and Directorate should be better understood and respected by all staff.
- 5.23 The Director of Clinical Services should ensure clinicians in management roles should receive appropriate training for their roles.
- 5.24 The Trust Board of Directors should ensure that until the divisional structure is stronger there is more direct input and accountability from senior management to support those already in post.
- 5.25 The Clinical Director (Cardiac, Vascular & Thoracic Surgery) should ensure that all relevant cardiac staff attend 'Human Factors' Training within a reasonable time period.
- 5.26 Consideration should be given to widening 'the team' undergoing the Human Factors training to include, for example, Divisional and Directorate senior management.
- 5.27 Consideration should be given to general team-building at both Divisional and Directorate level, for example by the use of 'Listening into Action', an approach identified to 'engage and empower clinicians and staff around any challenge' (quote taken from Listening into Action website). It aims to empower teams and support staff who have felt helpless.. As an approach that is led by the Chief Executive and supported by clinical and operational leaders this would be a powerful tool to utilise. Such team-building should include work on Trust values and aims.
- 5.28 Consideration should be given to team building between the Trust senior management and Divisional senior management, separately from any wider work that may be undertaken with senior management for all divisions.
- 5.29 Waiting lists need better management to establish equity of access to patients for routine surgery, and consideration should be given to developing a common waiting list for straightforward procedures.
- 5.30 There should be more regular and better attendance by all surgeons at cardiac surgical meetings to improve team dynamics. Initially, these meetings should be facilitated by the Clinical Director (Cardiac, Vascular & Thoracic Surgery).

Recommendations to ensure staff are aware of how to and continue to feel able to raise concerns

- 5.31 The Trust Board of Directors continues to follow good practice and review all relevant Trust Policies such as *Raising Concerns Policy* and *Incident Reporting Policy* to ensure up-to-date and available via Trust dissemination methods to all staff.
- 5.32 The Divisional General Manager should hold a briefing session with all staff to remind them of the methods for raising concerns and responsibilities at all levels, for example raising, recording, investigating of and responding to concerns.

Recommendations in relation to the responses to any patient safety concerns raised by the cardiac centre staff, in terms of effectiveness of any action taken by management team to investigate and address the concerns

- 5.33 The Divisional General Manager acts as the central point for collation of evidence in relation to raising of and the subsequent response to issues and concerns raised outside of the Raising Concerns Policy.

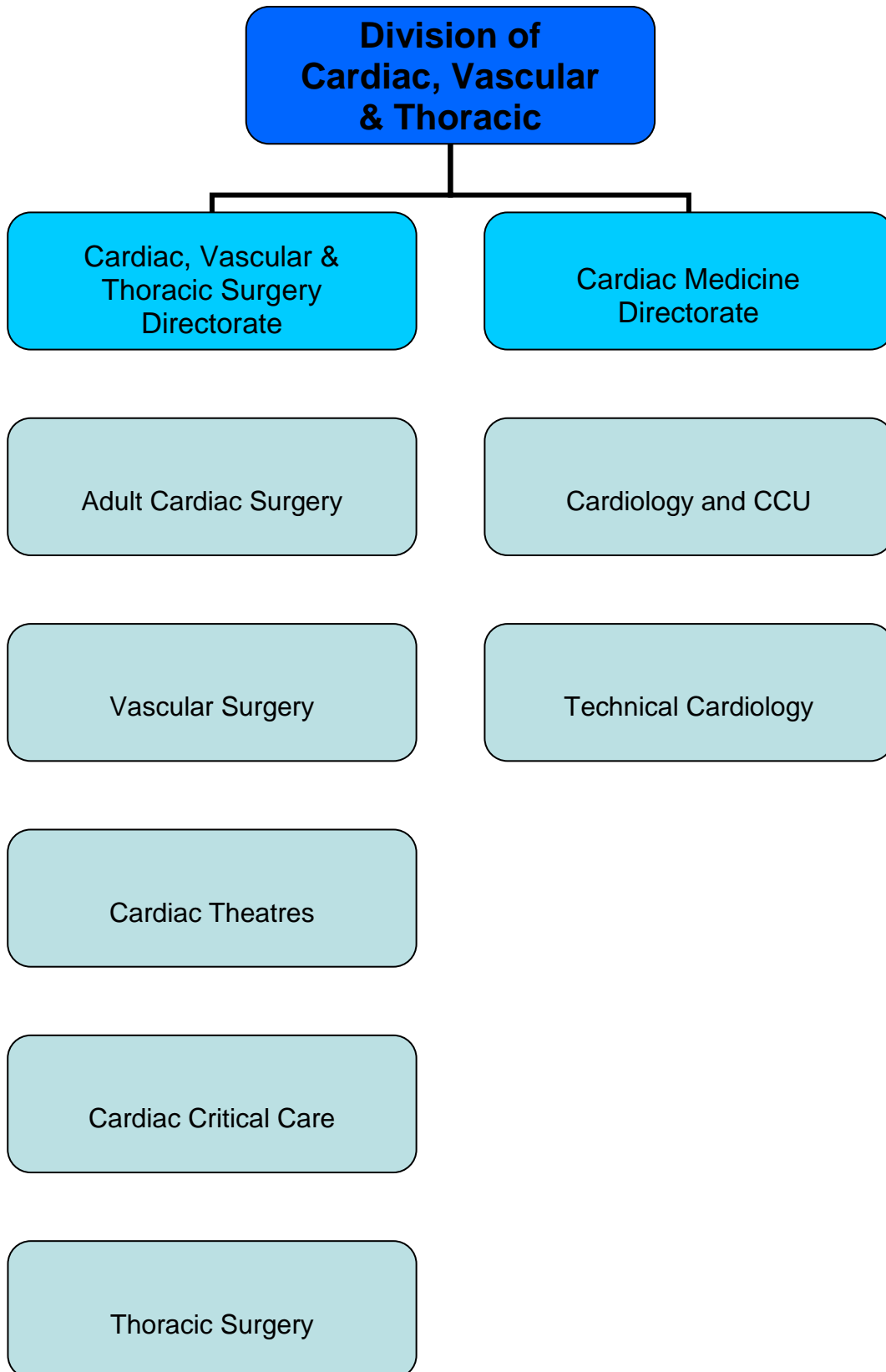
Recommendations in relation to Divisional Strategy

- 5.34 The already approved Outline Business Case for the expansion of cardiac surgery should be further endorsed. This would give a boost to staff morale.
- 5.35 The time-table should be identified and the workforce planning programme to enable implementation of the plan should be overtly pursued.
- 5.36 The capital development particularly in relation to theatres and CTCCU should begin in order to be able to achieve the ambition of an expanded safe and sustainable cardiac surgical service.
- 5.37 Moves should continue to establish a consultant delivered 24/7 service across the whole Oxford Heart Centre.

6. Acknowledgements and Comment

- 6.1 The Review Team would like to acknowledge the members of staff who were interviewed during this review for their willingness to participate and their positive approach to the process. In addition we are grateful for all the documentation collected and collated on our behalf and assistance generally provided.
- 6.2 We hope our review will help the Oxford Cardiac Surgical Unit to continue to grow in scope and strength to achieve its ambitions. We are aware of the inevitable potential disruption that successive reviews can bring and hope our recommendations go some way to mitigate against further problems. We wish the unit well for a sustained and secure future for its patients.

Appendix 1 – Cardiac, Vascular and Thoracic Divisional Structure Chart



Appendix 2 – Staff Interviewed

The following members of staff, who unless otherwise stated work within the cardiac unit, were interviewed as part of this review. The titles are as provided by the Trust:

Medical Director	Practice Development Nurse
Director of Clinical Services	Surgical Care Practitioner
Deputy Chief Nurse	Patient Access Manager
Consultant Microbiologist/Infectious Disease	Lead Consultant Thoracic Surgeon
HR Consultant (for the Division)	Nursing staff (theatre, outpatients and ward) including Band 5, Band 6, Band 7
Divisional Director	Senior Perfusionist
Divisional Nurse	Locum Perfusionist
Divisional General Manager	Consultant Intensivist
Clinical Director	Consultant in Surgical Echo-Cardiology
Clinical Lead, Consultant Cardiothoracic Surgeon	Band 5 Operational department practitioner (ODP)
Cardiologist and Clinical Lead	Senior ODP
Consultant Anaesthetists	Senior ODP Cardiac Anaesthetics
Consultant Cardiothoracic Surgeons	Clinical Support Worker
Cardiac Directorate Matron	Practice Educator
Cardiac Theatres Critical Care Unit Lead Nurse	Clinical Governance and Risk Practitioner (for the Division)
Cardiac Directorate Operational Service Manager	Lead Surgical Care Practitioner
Cardiology Directorate Operational Service Manager	

Appendix 3 – Documentation Reviewed

The following documentation was provided as part of this review:

1. Trust Organisational Structure Chart
2. Cardiac, Vascular and Thoracic Divisional Management Structure Chart
3. Trust Overview of Governance Provisions, February 2013
4. Investigation into Cardiothoracic Surgical Services at the Oxford Radcliffe Hospitals NHS Trust, March 2007, Healthcare Commission
5. Trust Management Executive reports
6. Clinical Governance Committee Papers
7. Coronary Artery Bypass Graft (CABG) (other) Mortality Action Plan submitted to the Care Quality Commission on 26 March 2013
8. Full Cardiac Staffing List Spreadsheet
9. Cardiac Surgery Theatre Utilisation Report, June 2013 and email explaining the data in the report
10. Cardiothoracic and Vascular Surgery Directorate Meeting agendas and minutes
11. Cardiac, Thoracic and Vascular Division Executive Meeting agendas and minutes
12. Cardiac, Thoracic and Vascular Quality Scorecards
13. Terms of Reference for Divisional Board, Divisional Executive Meeting and Divisional Governance Meeting
14. Statutory and Mandatory Training Policy, version 9, February 2013
15. Statutory and Mandatory Training Compliance, Cardiothoracic and Vascular Theatres
16. Vacancy , May 2013
17. Attendees at Human Factors Training 10th May 2012, 28th June 2012 and 20th September 2012
18. Emails about Agency use / staffing
19. Amalgamation into Cardiothoracic Critical Care Unit (CTCCU) Staff Survey Results Slides
20. Amalgamation into Cardiothoracic Critical Care Unit (CTCCU) Staff Survey Results One Year After Integration Slides
21. Cardiac Thoracic and Vascular Division Patient Questionnaire Cardiothoracic Critical Care Unit (CTCCU)
22. Cardiac Thoracic and Vascular Division Patient Questionnaire Cardiothoracic Ward

23. Cardiac Thoracic and Vascular Performance Compact Review Meeting report and minutes
24. Quality Report to Clinical Governance Committee, 17th October 2012
25. Cancer Pathway Performance Meeting Report, 30th October 2012
26. Cardiac, Thoracic and Vascular Quality Impact Assessment Cost Improvement Programme, November 2012
27. Cardiac Surgery Action Plan Revised from Trust Management Executive paper, 22nd November 2012
28. Emails and letters in relation to issues raised
29. Notices of Absences information
30. Cardiothoracic Surgery Operation List
31. Oxford Heart Centre Development Paper to Planning Committee Meeting, 2010 and attachments
32. Oxford Heart Centre Business Case Appraisal, 26th March 2013
33. Oxford University Hospitals Trust Benchmarking Data Source National Cardiothoracic Benchmarking Collaborative
34. Oxford Vascular Unit Performance in comparison with UK national outcomes, Divisional Executive Meeting, 7th January 2013
35. Oxford Vascular Unit Performance in comparison with UK national outcomes, Divisional Executive Meeting, 6th February 2013
36. Cardiac, Thoracic and Vascular Division Readmissions Audit Report
37. Reducing Surgical Site Infection within Cardiac Surgery Report, Performance Compact Meeting, December 2012
38. Private Patients Service Devolution Project Update, January 2013
39. Breakdown of Staff Appraisals for Cardiac, Thoracic and Vascular Division; Theatres, Anaesthetics, Perfusionists and Surgical Care Practitioners (showing consultants appraisals)
40. Vascular surgery long length of stay patient pathways, Divisional Executive Meeting, 29th April 2013
41. Proposed restructure of the regional vascular surgery directorate to assist in the delivery of the regional vascular development and recommendations made by the external review of vascular surgery 2012, Divisional Executive Meeting 29th April 2013
42. Intellectual Property Policy, version 5, November 2012

43. Incident Reporting & Investigation Policy, version 9, October 2012
44. Oxford Radcliffe Hospitals Policy on Working Time Regulations (under review), version 2, July 2007
45. Working Time Regulations Procedure and Guidance, version 1, March 2013 (no issue date)
46. Complaints list for the period 1st May 2012 to 2nd July 2013
47. Incidents list for the period 1st April 2012 to 30th June 2013
48. Divisional Risk Registers April 2012 to May 2013
49. Cardio, Thoracic and Vascular Surgery Directorate Risk Register as of 2nd July 2013
50. Raising Concerns Policy, version 4, April 2011 (under review)
51. Cardiac and Thoracic Critical Care Unit (CTCCU) Annual report 2011-12
52. Cardiac and Thoracic Critical Care Unit (CTCCU) Annual report 2012-13
53. Divisional Sickness Statistics (January to July 2013)
54. Trust Sickness Standard
55. Minutes of other meetings as requested, for example Multi-disciplinary Team Meetings

The following guidance was used as part of this review:

56. Staffing for patient in the perioperative setting 2008
57. Service Specification Adult Critical Care, NHS England 2013
58. National Guidance – Staffing for Patients in the perioperative setting 2008, Association for Perioperative Practice
59. Cardiothoracic Guidance – National Cardiothoracic Benchmarking Collaborative Annual Data Report 2011/2012
60. National Guidance Service Specification Adult Critical Care NHS England, June 2012
61. Standards for Nurse Staffing Adult Critical Care Consultation Document June 2013
Draft to be incorporated into General Principles for Intensive Care Services

In addition part of the Review Team:

- Attended a cardiac theatres monthly meeting
- Visited the Oxford Heart Centre

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Appendix 2 - External Cardiac Review Recommendations October 2013

Ref	Recommendation from the Report	Response	Comment	Agreed Action	Lead	Timescale
Recommendations to address concerns about the cardiac theatres service, with specific reference to issues of patient safety and staffing:						
5.1	The Trust Board of Directors should continue to follow good practice and, using current governance systems, review patient safety and staffing issues in relation to the cardiac unit.	Accepted	The recommendation is based on the Report premise that the Cardiac Business Case will be fully implemented.	Mortality & Morbidity process within the Division will be strengthened and a clear process for systematic monitoring of outcomes and closing down learning actions from monthly review process will be documented. The Division will: <ul style="list-style-type: none"> Undertake a staffing gap analysis between current position and business case proposals in relation to staffing levels Provide a quarterly review of progress via the Q3 and Q4 performance meetings and submit updates to the Trust Board. 	Bernard Prendergast Belinda Boulton Directorate Management Team	20 th December 2013 22 nd November 2013 January and April 2014
Recommendations to ensure continued patient safety within the unit and to address specific concerns raised by staff at interview						
5.2	The Trust Board of Directors should seek assurance from the interim Divisional Director that all relevant Trust Policies are being followed at Divisional level.	Accepted	Already addressed as reported monthly via Governance Framework with monthly monitoring audits which are incorporated into the Divisional to become Directorate performance report.	Continue current good practice of monthly audits and performance reporting. The Trust Board should ask the Quality Committee to monitor this action. An initial report to be provided to the Quality Committee via the Clinical Governance Committee setting out the Safety Policies monitored on a monthly basis.	Directorate Team Paul Brennan	Monthly 18 th December 2013 Clinical Governance Committee 12 th February 2014 Quality Committee
5.3	The interim Divisional Director should facilitate the completion of defined and agreed Standard Operating Procedures. Common Standard Operating Procedures need to be agreed and implemented for the vast majority of routine patient care, taking good practice from other units.	Accepted	Involve team in development.	Standard Operating Procedures will be written for: <ul style="list-style-type: none"> Pre-operative assessment Patient Management within ITU Inter-operative management Post discharge follow-up/management. 	Rana Sayeed Shane George Mario Petrou Rana Sayeed Chris Palin	Drafted and agreed by 13 th January Implemented 3 rd February

Ref	Recommendation from the Report	Response	Comment	Agreed Action	Lead	Timescale
5.7	Consideration should be given by the Divisional Nurse to ensuring a more equal balance of cardiothoracic/cardiology nursing leadership.	Considered	Relates to nursing leadership in CTCCU.	Overall responsibility rests with the Matron who is an experienced Cardiothoracic Nurse; the Lead Nurse for CTCCU is an experienced Cardiology Nurse who is supported by an experienced Cardiothoracic Sister/Charge Nurse Tier. The combined CCU/ITU is viewed highly by colleagues who have visited from other units and regarded as the future service model. The Lead Nurse has the full confidence and support of all members of the Team.		Completed
5.8	A further evaluation of stakeholders in relation to CTCCU should be undertaken.	Accepted	Relates to management of CTCCU and Theatres and deployment of anaesthetic and intensivist resource.	<p>Set out rules for allocation of anaesthetic sessions to cath labs/ theatre/ITU/pre-admission clinics together with continuity of work pattern for ITU. This will include timetabled theatre list allocations for the Intensivists.</p> <p>Create new clinical service unit to cover anaesthetics and CTCCU with a single clinical lead.</p> <p>Rules to be translated into job plans.</p>	<p>Belinda Boulton and Linda Hands</p> <p>Clinical Director</p> <p>Divisional and Clinical Director</p>	<p>22nd November 2013</p> <p>1st December 2013</p> <p>31st January 2014</p>
<i>Recommendations to address issues in relation to maintaining the correct level of expertise and trained staff to undertake procedures and provide suitable support in cardiac theatres</i>						
5.9	The Trust Board of Directors should consider removing vascular surgery to its own or another directorate.	Accepted		Vascular Surgery will now form part of the Specialist Surgery Clinical Directorate.	Paul Brennan	Completed
5.10	The Clinical Director (Cardiac, Vascular & Thoracic Surgery) should ensure that there are up-to-date job plans and annual appraisals all surgeons.	Accepted	New job planning guidance will be issued in November 2013.	<p>Job plans will be completed.</p> <p>Appraisals will be completed.</p>		<p>31st January 2014</p> <p>31st March 2014</p>

Ref	Recommendation from the Report	Response	Comment	Agreed Action	Lead	Timescale
5.11	The Trust Board of Directors should continue to review statutory and mandatory training compliance for the Division and Directorate to ensure compliance with the Trust standard of 95% on an ongoing basis.	Accepted	Current 87%. Need to address denominator issues both on and off.	Develop plan to deliver 95%. Achieve compliance	Directorate Management Team Directorate Management Team	29 th November 2013 31 st January 2014
5.12	The Clinical Director (Cardiac, Vascular & Thoracic Surgery) should review statutory and mandatory training at staff group level and liaise with professional leads for these groups to ensure high level of compliance for all subjects and at all levels.	Accepted	Current 87%. Need to address denominator issues both on and off.	Develop plan to deliver 95%. Achieve compliance	Directorate Management Team Directorate Management Team	29 th November 2013 31 st January 2014
5.13	The Matron/Lead Nurse should spend time working in the clinical areas they manage alongside frontline clinical staff, for example three days per month working a clinical shift in theatre. This would give visibility to the surgeons regarding the senior nursing team and greater informal communication links for their nursing staff.	Accepted	High level of visibility acknowledged in report at paragraph 4.45.	The Matron currently undertakes clinical work in ITU and the Cardiac ward and will undertake further clinical days in theatre equating to three clinical shifts per month.	Sarah Malone	31 st December 2013
5.14	The Matron/Lead Nurse should develop a comprehensive skills matrix for CTCCU and Cardiac theatres in order to ensure robust skills development in these specialist fields alongside mandatory training requirements.	Accepted	Skills at each band linked to patient dependency.	<ul style="list-style-type: none"> • Outcome of Trust-wide dependency and acuity review will be completed. • Reconciliation of current staffing levels and outcome of dependency/acuity audit • Each band of nurse will have a skills matrix developed • Each individual nurse will have a completed competency framework which will be held within the Unit. 	Liz Wright Sarah Malone/Liz Wright Sarah Malone Sarah Malone	22 nd November 2013 21 st February 2014 18 th April 2014 30 th June 2014
5.15	The Matron/Lead Nurse should plan to ensure regular nursing staff meetings within cardiac theatres as well as the theatre users group to promote good communication within the theatre nursing team.	Accepted		Monthly meetings in place and minuted.	Sarah Malone	Completed

Ref	Recommendation from the Report	Response	Comment	Agreed Action	Lead	Timescale
5.16	Greater consideration needs to be given to the theatre team and having a much more modern approach to the theatre work with scrub and anaesthetic practitioners being able to work in both specialities allowing a much more flexible approach to staffing theatres safely.	Accepted	The scrub nurses and anaesthetic practitioners have different skill sets and creating a generic role could lead to dilution of skills.	Recommendation considered and the Clinical Directorate will benchmark practice nationally to assess models adopted in other centres. Manage as a single team.	Sarah Malone Sarah Malone	31 st January 2014 28 th March 2014
5.17	Formal competency packages for theatre and CTCCU, including for Clinical Support Workers, should be developed to address not only issues of safe practice but also concerns about knowledge and skills raised by consultant bodies.	Accepted		In place already, may be misunderstanding linked to Assistant Practitioner role who undertakes procedures under the direct supervision of a registered nurse at all times and competency assessed. An audit of CSW competency packages in place for CTCCU and Theatres will be undertaken.	Sarah Malone and Practice Development Nurses Sarah Malone and Practice Development Nurses	Completed 31 st December 2013
5.18	Succession planning should be in place for senior consultants and surgeons, to avoid lack of expert service provision and to enable future planning.	Accepted	Discussions are underway with colleagues around succession planning.	Within the context of Trust HR policies, succession plans will be agreed in advance to enable early recruitment and skills handover.	Paul Brennan and Chris Kennard	21 st March 2014
5.19	Formal mentorship should be in place particularly for new consultants.	Accepted		Whilst the recommendation is accepted the Trust already has a mentoring programme in place for new consultants, which is reported to the Trust Board. All recent consultant appointments have been allocated a mentor. A review of mentoring arrangements for all other staff groups will be undertaken.	Ruth Titchener	Completed 21 st April 2014

Recommendations to address issues of team dynamics within the cardiac centre, including the culture within the team						
5.20	The Trust Board of Directors should give consideration to how the Division and Directorate is strengthened and proposed changes to personnel in posts for November 2013 brought forward.	Accepted	This relates to Divisional and Clinical Director roles and has been overtaken by the revised organisational arrangements.	The Trust Board received and approved proposals for realigning and strengthening the Divisional Structure. Divisional Director post advertised and interviews arranged. Appointments for other posts will follow Divisional Director appointment.	Paul Brennan	Advertised 8/10/13 Interview 29/10/13 All postholders will be in place by 31/11/13
5.21	Consideration should be given to recruiting, externally, a senior lead cardiac surgeon.	Accepted		Adopting approach set out in 5.18. Consideration should be given as part of succession planning.		
5.22	The Director of Clinical Services should give consideration to how leadership roles and responsibilities within the Division and Directorate should be better understood and respected by all staff.	Accepted		Updated job profiles for Divisional and Clinical Directors to be provided. Role and responsibility of Clinical Service Unit lead role to be standardised and Trust wide job profile to be created.	Paul Brennan Paul Brennan	1 st November 2013 20 th December 2013
5.23	The Director of Clinical Services should ensure clinicians in management roles should receive appropriate training for their roles.	Accepted		Development programme to be formulated in conjunction with new appointments to Divisional and Clinical Director posts	Paul Brennan and Paul Jones	28 th February 2014
5.24	The Trust Board of Directors should ensure that until the divisional structure is stronger there is more direct input and accountability from senior management to support those already in post.	Accepted	Clarity around roles in structure.	Proposals were considered and approved at the Trust Board meeting in September 2013 associated with the changes to the organisational structure.		Completed
5.25	The Clinical Director (Cardiac, Vascular & Thoracic Surgery) should ensure that all relevant cardiac staff attend 'Human Factors' Training within a reasonable time period.	Accepted		Two ambassadors for Human Factors training in place. 6 sessions being planned in stimulation lab covering all staff Cardiac/Cardiology focussed as session about 20.	Paul Brennan and Sarah Malone	14 TH February 2014 to start training programme
5.26	Consideration should be given to widening 'the team' undergoing the Human Factors training to include, for example, Divisional and Directorate senior management.	Accepted		See 5.25.		

5.27	Consideration should be given to general team-building at both Divisional and Directorate level, for example by the use of 'Listening into Action', an approach identified to 'engage and empower clinicians and staff around any challenge' (quote taken from Listening into Action website). It aims to empower teams and support staff who have felt helpless.. As an approach that is led by the Chief Executive and supported by clinical and operational leaders this would be a powerful tool to utilise. Such team-building should include work on Trust values and aims.	Accepted		A theme focussed programme will be developed for the new Directorate (Cardiac & Cardiology) and will specifically incorporate team building, managing challenging behaviour, leadership skills and multidisciplinary team working, enhanced communications and living the Trust values as a key component of service provision.	Paul Brennan, Paul Jones and Jane Rowley with support from Bernard Prendergast, Nicola Robertson, Ruth Titchener, Sarah Malone,	Programme developed by 1 st March2014 and to run throughout the year.
5.28	Consideration should be given to team building between the Trust senior management and Divisional senior management, separately from any wider work that may be undertaken with senior management for all divisions.	Accepted		Will form part of the development programme covered under 5.27	As 5.27	As 5.27
5.29	Waiting lists need better management to establish equity of access to patients for routine surgery, and consideration should be given to developing a common waiting list for straightforward procedures.	Accepted	Linked to referrals from cardiologists to specific consultants with common theme relating to communication and aftercare rather than specific operative skills.	This has been addressed via agreement to manage certain procedures on a shared waiting list, an additional clinic out of Oxford being undertaken by a Surgeon and agreement to fully comply with the Trust Elective Access Policy to ensure the flow of patients between lists to meet 18 week RTT. A proactive analysis of list size and adherence to the access policy will be undertaken on a monthly basis from December 2013 to June 2014	Ruth Titchener	Completed Each month from January 2014 through to July 2014
5.30	There should be more regular and better attendance by all surgeons at cardiac surgical meetings to improve team dynamics. Initially, these meetings should be facilitated by the Clinical Director (Cardiac, Vascular & Thoracic	Accepted	Note this has been actioned	1 st Wednesday each month 8am surgeons meeting established – meeting minuted. All consultants expected to attend minimum 8out of the 12 meetings each	Rana Sayeed Rana Sayeed	Completed 30 th June 2014

	Surgey).			year. Attendance to be audited and outcomes reported to the Director of Clinical Services to determine the value of the meeting.		
Recommendations to ensure staff are aware of how to and continue to feel able to raise concerns						
5.31	The Trust Board of Directors continues to follow good practice and review all relevant Trust Policies such as <i>Raising Concerns Policy</i> and <i>Incident Reporting Policy</i> to ensure up-to-date and available via Trust dissemination methods to all staff.	Accepted		Policy reviewed and amendments' were approved by the Trust Board in 2013. The Incident Reporting Policy was amended and approved by the Trust Management Executive in 2013		Completed Completed
5.32	The Divisional General Manager should hold a briefing session with all staff to remind them of the methods for raising concerns and responsibilities at all levels, for example raising, recording, investigating of and responding to concerns.	Accepted		Briefing sessions have been held by the Director of Clinical Services in October 2013.		Completed
Recommendations in relation to the responses to any patient safety concerns raised by the cardiac centre staff, in terms of effectiveness of any action taken by management team to investigate and address the concerns						
5.33	The Divisional General Manager acts as the central point for collation of evidence in relation to raising of and the subsequent response to issues and concerns raised outside of the Raising Concerns Policy.	Accepted	.	The Operational Services Manager will act as the central point for issues raised outside the Raising Concerns Policy within the Directorate		Completed
Recommendations in relation to Divisional Strategy						
5.34	The already approved Outline Business Case for the expansion of cardiac surgery should be further endorsed. This would give a boost to staff morale.	Accepted		Actions as set out under 5.1 and 5.35		
5.35	The time-table should be identified and the workforce planning programme to enable implementation of the plan should be overtly pursued.	Accepted		<ul style="list-style-type: none"> Gap analysis – funded posts Confirm funding in budget 	Operational Services Manager Directors of	22 nd November 2013 31 st December

				<ul style="list-style-type: none"> Recruitment programme Staff in post 	<p>Clinical Services and Finance Operational Services Manager and Matron</p> <p>Operational Services Manager and Matron</p>	<p>2013</p> <p>31st December 2013 to 30th June 2014</p> <p>30th June 2014</p>
5.36	The capital development particularly in relation to theatres and CTCCU should begin in order to be able to achieve the ambition of an expanded safe and sustainable cardiac surgical service.	Accepted	Linked to Trust wide JR Theatre Business Case. 2 rooms in CTCCU opened 1 st August 2013.	<p>Trust wide theatre Strategic Outline Case to be completed.</p> <p>Outline Business Case to be completed</p>	<p>Paul Brennan</p> <p>Paul Brennan</p>	<p>31st January 2014</p> <p>31st May 2014</p>
5.37	Moves should continue to establish a consultant delivered 24/7 service across the whole Oxford Heart Centre.		The Trust will work with the review team to understand the rationale for the recommendation to implement 24/7 delivered/resident consultant care in Cardiac Surgery, Cardiac Critical Care, Thoracic Surgery and Cardiology			

List of Leads and Job Titles:	
<p>Bernard Prendergast – Clinical Director Cardiology</p> <p>Belinda Boulton – General Manager, Cardiac, Vascular & Thoracic</p> <p>Rana Sayeed – Consultant Cardiothoracic Surgeon</p> <p>Shane George – Cardiothoracic Critical Care Intensivist</p> <p>Mario Petrou – Consultant Cardiothoracic Surgeon</p> <p>Chris Palin – Consultant Anaesthetist</p> <p>Sarah Malone – Matron, Cardiac, Vascular & Thoracic Surgery</p> <p>Chris Kennard – Divisional Director</p>	<p>Linda Hands – Clinical Director, Cardiac, Vascular & Thoracic Surgery</p> <p>Liz Wright – Acting Chief Nurse</p> <p>Paul Brennan – Director of Clinical Services</p> <p>Ruth Titchener – Operational Services Manager, Cardiology</p> <p>Paul Jones – Interim Director of Workforce</p> <p>Jane Rowley – Head of Organisational Development</p> <p>Nicola Robertson – Matron, Cardiology</p>

**Mr Paul Brennan, Director of Clinical Services
November 2013**

