Briefing on Independent Review of Cardiac Theatres and the Cardiac Surgical Unit at the John Radcliffe Hospital

Oxford University Hospitals NHS Trust received an Independent Review into its Cardiac Theatres and the Cardiac Surgical Unit at the John Radcliffe Hospital at the meeting of the Trust Board on Wednesday 13 November. The Board also agreed an action plan written to address points raised in the review.

The Review was commissioned following concerns raised internally and externally about staffing in the unit and about the Trust's whistle-blowing arrangements. The independent review panel examined these concerns and was clear that there were no problems with staffing and it had no concerns regarding the Trust's whistle-blowing procedures.

The Review commended the clinical care provided within the unit and had no concerns for patient safety. However, the Review did raise some issues on management structure, the culture of the working environment and training compliance. The Director of Clinical Services has worked with staff in the Unit to look at each recommendation. The action plan indicates whether the recommendation is accepted and what action will be taken as a result. Many of the recommendations were to continue with existing practice and some have been overtaken by a reorganisation of the Trust's clinical management structure which was already planned when the Review report was received.

Why was the review commissioned?
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. The Medical Director agreed to investigate these concerns and notified the Trust Board of his intended action at the Trust Board meeting in March 2013.

In addition, on 12th March the Care Quality Commission (CQC) contacted the Trust to inform them that a 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.

Commissioning of the review
Given the nature of the concerns and the fact that they had been raised internally and externally through the regulator, the Chief Executive decided to commission an external independent review of the issues raised rather than completing an internal

investigation. The CQC supported this action. 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.

The Trust sought recommendations for a cardiac surgeon to lead a review from Sir Bruce Keogh, Medical Director of NHS England and an independent multi-disciplinary review team was established in spring 2013.

Scope of the review

The scope of the review was to

- Identify and address any relevant concerns arising during the review in relation to patient safety and staffing within cardiac theatres;
- Investigate and comment upon OUH's response to identified issues regarding patient safety and/or staffing since Spring 2010 to the present within Cardiac Theatres, with specific regard to the scope, adequacy and effectiveness of that response.

The review was conducted in an open and transparent manner and all staff involved in the unit were encouraged to share their experiences to enable the investigation to identify any shortfalls in standards of care. In the end, 25% of all staff in the unit spoke to the reviewers - some more than once.

Publication of the report

The report was published with the papers for the Trust's Board of Directors meeting on 13 November. The Trust has shared the report with the staff in cardiac surgery and cardiology. The Trust has also shared the report with the CQC, its commissioners and the Trust Development Authority.

Review findings

The review found 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. The reviewers also looked at the team dynamics and surgical leadership as part of its report and found that there were issues which they thought should be addressed in terms of the structure, surgical leadership and improved team working.

The review team also made 37 recommendations to support further improvement and development within the cardiac team. Many of these recommendations were to continue with work that was already being done.

Implementation of the report's recommendations

The Trust shared the report with divisional staff (meetings for all divisional staff were held on Tuesday 8 October and Thursday 10 October). The Director of Clinical Services then led a group of staff to consider the recommendations of the report in detail and develop actions where appropriate.

The action plan has now been agreed by the Trust's Board of Directors on 13 November and will now be implemented. It should be noted that the report contains some recommendations that are to continue with existing policies and practice as well as others which require new actions.

There is an error in the assumption in recommendation 19 that the Trust does not have a mentorship programme at the moment. For the last 18 months all newly appointed consultants have had mentors.