RCS INVITED REVIEW OF CARDIOTHORACIC SURGERY SERVICE - ACTION PLAN

Belfast Health and Social Care Trust
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DATE OF LAST UPDATE 19 September 2022

	Potential Cause for Concern Raised	*Action No.*	Required Action(s)	Lead for Completion	RAG Status
	1-12 Initial recommendations following RCS review				
1	The whole consultant team should learn and understand acceptable behaviours in dealing with each other, junior staff and other colleagues, including nursing staff. The review team heard reports of undermining and derogatory comments and behaviour, and this should stop. The Trust management should encourage this learning to support positive change and not use it as a punitive exercise. However there should be a clear escalation of proportionate	***1.1***	Meeting to be held with consultant staff on Trust values and MHPS standards and chaired by MD	[redacted]	Complete
		1.2	A values-based exercise to be scoped for all cardiothoracic consultants	[redacted]	Complete
		1.3	Virtual values based exercise to be delivered	[redacted]	Complete
		1.4	Face to face values based exercise to be delivered	[redacted]	In Progress
2	The review team heard reports of challenging and undermining behaviour on the Friday 'grand round', on ward 5A, often in front of patients. The 'grand round' is also unnecessarily large and cumbersome and can be intimidating for patients. Therefore the review team recommend the Friday 'grand round' should be stopped immediately.	***2.1***	Stop the 'grand round' immediately	[redacted]	Complete
3	The review team heard conflicting reports about attendance at the daily 8.00 a.m. theatre briefing in the Thoracic and Cardiac theatres. The review team recommend that the whole theatre team, including consultants, must be present at the briefings.	***3.1***	Review of job plans to support attendance at 8.00 daily theatre briefings	[redacted]	Complete
		3.2	Audit attendance of daily 8.00am theatre briefings in cardiac theatres	[redacted]	Complete
		3.3	Audit attendance of daily 8.00am theatre briefings in thoracic theatres	[redacted]	Complete
4	Furthermore during the completion of the WHO checklist, consultants should be present on every occasion.	***4.1***	Review of job plans to support attendance at 8.00 daily theatre briefings	[redacted]	Complete
		4.2	Audit of consultant attendance when WHO checklist is completed	[redacted]	Complete
5	The Trust should develop clear responsibilities for out of hours cover for inpatients from the consultant surgeons.	***5.1***	A standard operating procedure to be developed to detail responsibilities of the consultant on-call - cardiac	[redacted]	Complete
		5.2	A standard operating procedure to be developed to detail responsibilities of the consultant on-call - thoracic	[redacted]	Complete
6	In the Cardiac ICU all patient management should, from now on, be channelled through the intensivists.	***6.1***	Discussion between surgical and anaesthetic leads regarding governance arrangements and responsibilities of patient	[redacted]	In Progress
		6.2	Agreement/ SOP regarding trigger for escalation for consultant surgeon involvement	[redacted]	In Progress
		6.3	Protocol for change of named consultant whilst patient in ICU	[redacted]	In Progress
7	The Trust should introduce common management protocols for post-operative conditions and/or situations, including, but not limited to, atrial fibrillation, anti-coagulation and peril-operative thromboembolism prophylaxis.	***7.1***	Introduce common management protocol for post-operative conditions - Atrial Fibrillation	[redacted]	Complete
		7.2	Introduce common management protocol for post-operative conditions - anticoagulation for cardiac patients	[redacted]	Complete
		7.3	Introduce common management protocol for post-operative conditions - anticoagulation for thoracic separate	[redacted]	Complete
		7.4	Introduce common management protocol for peril-operative thromboembolism prophylaxis	[redacted]	Complete
		7.5	Introduce common management protocol for chest drains - cardiac patients	[redacted]	Complete
		7.6	Introduce common management protocol for chest drains - thoracic patients	[redacted]	Complete
8	The Trust should audit all patients who have had a wedge resection for lung cancer. This should review the appropriateness of the procedure, identify, and if necessary treat, patients at risk of early local recurrence. This should cover the past two years and the whole consultant surgeon team.	***8.1***	Carry out an audit of all patients who have had a wedge resection within the last two years	[redacted]	Complete
9	The unacceptably long lung cancer waiting times need immediate focus and improvement.	***9.1***	Agree and ensure patients are 'worked-up' to agreed protocol prior to MDM	[redacted]	Complete
		9.2	Weekly scheduling meetings to include all available surgeons, WLO and ASM	[redacted]	Complete
		9.3	Consultants to pool patients to even waiting times	[redacted]	Complete
		9.4	Monitor theatre availability and usage monthly	[redacted]	Complete
10	The review team were concerned about the condition of the Cardiac theatre corridors, adjoining rooms and lift areas and the existing premises should be refurbished whilst awaiting the move to new premises. The appearance was not professional and did not give confidence that high calibre cardiac surgery would be performed there. In particular the condition of the paintwork, plasterwork and lighting should be addressed and a declutter of the area, including notices which appeared to be out of date, should take place.	***10.1***	Declutter cardiac theatres	[redacted]	Complete
		10.2	Identify remedial works to be undertaken	[redacted]	Complete
		10.3	Refurbish cardiac theatres	[redacted]	Complete
11	The advertisement for the permanent thoracic consultant post should be withdrawn until the issues considered in this review are satisfactorily resolved.	***11.1***	Withdraw advertisement for permanent thoracic consultant	[redacted]	Complete
		11.2	Advertise locum consultant	[redacted]	Complete
		11.3	Appoint locum consultant	[redacted]	Complete
		11.4	Locum consultant takes up post	[redacted]	Complete
12	A comprehensive review of the five clinical records was not able to take place as a result of changes to the timetable which left no allocated time to review the records. From a preliminary review of the records the review team did not express any concerns. However the review team recommend that the Trust consider commissioning a separate clinical record review with particular specialist thoracic surgery input.	***12.1***	Commission a clinical record review with the RCS	[redacted]	Complete
		12.2	Report received	[redacted]	Complete
		12.3	Development of Action Plan	[redacted]	Complete
	1-37 Formal recommendations following the publication of RCS report				
F1	Departmental, and senior Trust management should reflect on how management structures, and Trust culture and values are perceived by a wide range of staff at all levels. The Trust should seek to improve this perception and properly embed positive values. Support for all staff should be led from the highest level.	***F1.1***	Review of Cardiothoracic Service Management structures	Divisional Team	Complete
		F1.2	Appointment of neutral interim Clinical Director. Supported by Senior medical leader and interim Chair of Division	Divisional Team	Complete
		F1.3	Appointment of External facilitator to undertake a listening exercise	[redacted]	Complete
		F1.4	A team building exercise to be commissioned on team working	[redacted]	In Progress
F2	Interactions and communication between the cardiothoracic surgical service management team and clinicians should be reviewed and improved.	***F2.1***	Monthly business meetings to be established. (Completed Job Plans being formalised)	[redacted]	In Progress
		F2.2	Fortnightly Surgeons meeting chaired by Interim CD to be established	[redacted]	Complete
F3	Coaching for managers and leaders should be considered in order to facilitate continuing improvement in management/leadership skills and values.	***F3.1***	Safety and Quality programmes provided	[redacted]	Complete
		F3.2	Training and development programme developed for middle managers and clinical leaders.	[redacted]	In Progress
F4	A system should be put in place where senior line management formally appraise Clinical Directors at appropriate intervals, ideally on a quarterly basis.	***F4.1***	Chair of Division to undertake Clinical Director's appraisal at the appropriate time in line with current arrangements.	[redacted]	Complete

F5	The consultant team, as a whole, must learn and understand acceptable behaviours in dealing with each other, junior staff and other colleagues, including anaesthetic and nursing staff. Undermining and derogatory comments and behaviour must stop. The Trust management should encourage this learning to support positive change and not use it as a punitive exercise. However, there should be a clear escalation of proportionate sanctions if unacceptable behaviour persists.	***F5.1***	Trust directors and NI NCAS (PPA) will hold meetings with Consultant team.	[redacted]	Complete
F6	If necessary, external facilitation should be considered to assist with addressing and rectifying interpersonal issues.	***F6.1***	External Facilitator will be appointed	[redacted]	Complete
F7	The Trust should investigate claims of alleged racial discrimination and abuse of BAME members of the surgical team, which the review team considered to be unacceptable and particularly concerning.	***F7.1***	Commission an external independent investigation. Investigation has been commissioned	[redacted]	In Progress
F8	The Trust should review the number and appropriateness of internal complaints and grievances being raised by surgeons, at all grades, against other surgeons in the service.	***F8.1***	MHPS process to be commenced	[redacted]	In Progress
F9	Restrictions on individuals surgeons practice should always be supported by robust evidence and data. This must follow open, clear, transparent and robust policies and procedures. Adequate governance for monitoring and auditing these procedures must be put in place.	***F9.1***	Independent Chairing of monthly Cardiothoracic M&M/Safety meetings to be established	[redacted]	Complete
		F9.2	Independent Chairing of weekly Thoracic Safety meetings to be established	[redacted]	Complete
F10	The unacceptably long lung cancer waiting times need immediate focus and improvement. Limiting steps/factors leading to long waiting times should be examined with a view to reducing their effect and enabling patients to be treated more quickly.	***F10.1***	Independent Review of thoracic patient pathways to improve access to diagnostics and prioritisation for surgery	[redacted]	Complete
F11	An improved mechanism for distributing in-house urgent patients should be introduced. It is recommended that this should involve a weekly, at a minimum, scheduling meeting where in-house urgent patients are allocated a surgeon and an operation slot. Sufficient administrative support should be provided.	***F11.1***	Patient scheduling/management meetings to be established. Develop team working and shared/pooled patient lists and responsibility arrangements.	[redacted]	Complete
F12	Innovative waiting list initiatives should be considered, including, where possible, weekend operating.	***F12.1***	Opportunities for waiting list initiatives, including weekend and Bank Holidays operating, to be explored	[redacted]	Complete
F13	The Trust should audit all patients who have had a wedge resection for lung cancer during the past two years, by all members of the consultant surgeon team This should review the appropriateness of the procedure, identify, and if necessary, treat patients at risk of early local recurrence.	***F13.1***	Audit to be undertaken followed by an External Review	[redacted]	Complete
F14	The Trust should establish a scheduling meeting for lung cancer surgery, so that those patients suitable for VATs lobectomy are identified and offered the procedure.	***F14.1***	VAT's meetings will be established when the Clinical Lead is appointed	[redacted]	complete
F15	In the Cardiac ICU all patient management should, from now on, be channelled through the intensivists.	***F15.1***	Management arrangements for cardiac patients in ICU to be discussed by the Clinical Director in liaison with the Clinical Director for Critical Care	[redacted]	complete
F16	The whole theatre team, including consultant surgeons, must be present at the 8:00 a m daily theatre briefings.	***F16.1***	The entire team will be present for 8am daily briefs	[redacted]	Complete
F17	During the completion of the WHO checklist, consultants should always be present on every occasion.	***F17.1***	The entire team will be present for WHO checklist	[redacted]	Complete
F18	There should be an end of day debrief with the operating surgeon present.	***F18.1***	The entire team will be present for end of day brief	[redacted]	Complete
F19	The Friday 'grand round' should be stopped immediately, replacing it with appropriate multi-disciplinary teaching, which is built around the needs of patients and is a constructive learning experience for all who attend.	***F19.1***	The grand ward will be stopped	[redacted]	Complete
F20	The Trust should develop clear responsibilities for out of hours cover for inpatients from the consultant surgeons.	***F20.1***	Consultant out of hour responsibilities have been formalised	[redacted]	Complete
F21	Consultant of the Week' should be re-established	***F21.1***	Consultant of the week will be established virtually during COVID19.	[redacted]	Complete
F22	All locum surgeons should be provided with job plans	***F22.1***	Locum surgeons to be provided with job plans	[redacted]	Complete
F23	The Trust should introduce common management protocols for post-operative conditions and/or situations, including, but not limited to, atrial fibrillation, anti-coagulation and peri -operative thromboembolism prophylaxis.	***F23.1***	Development of protocols for post operative conditions	[redacted]	Complete
F24	A review of the five clinical records was not able to take place as a result of changes to the timetable which left no allocated time to review the records. The review team recommend that the Trust consider commissioning a separate clinical record review with specific specialist thoracic surgery input.	***F24.1***	Clinical review to be undertaken	[redacted]	Complete
F25	Redacted				
F26	Inconsistencies with the status of private practice in the service, which has been a source of tension, should be addressed by the Trust.	***F26.1***	Opportunities for Private Practices within BHSCT to be explored when current waiting lists delays have been addressed	[redacted]	Await Start
F27	Succession planning for a substantive Clinical Director of the cardiothoracic service should be a priority for the Trust.	***F27.1***	Trust will advertise and recruit substantive Clinical Director.	[redacted]	Complete
F28	Clinical Lead Roles in the service should be re-established.	***F28.1***	Trust will re-establish new clinical leadership roles	[redacted]	Complete
F29	The Trust should reconfigure its consultant workforce so all consultant surgeons practice exclusively either cardiac or thoracic surgery, including on call arrangements.	***F29.1***	Reconfigure Consultant workforce to establish exclusive specialist practice (Cardiac or Thoracic)	[redacted]	In Progress
F30	For the period in which mixed-practice is in place, mixed-practice surgeons should attend all meetings, including thoracic meetings, as required.	***F30.1***	The Cardiothoracic surgeons will attend all required meetings	[redacted]	Complete
F31	Consultant and management meetings should be formally timetabled in job plans outside of elective clinical working time.	***F31.1***	Consultant Lead job plans will include management meetings currently being updated	[redacted]	Complete
F32	The Trust should review the IT system in ICU and consider a dedicated pharmacist in Cardiac ICU.	***F32.1***	All IT Hardware been replaced and initial scoping exercise been undertaken to provide new Carevue system in CSICU.	[redacted]	Complete
		F32.2	Review the role of a dedicated pharmacist in CSICU	[redacted]	Complete

F33	Responsibility for decision-making in the ICU could be a source of dispute between surgeons and anaesthetists. All clinical management decisions should be channelled through the ICU consultant.	***F33.1***	Clinical Director to address this recommendation with Anaesthetic counterpart	[redacted]	Complete
F34	The advertisement for the permanent thoracic consultant post should be withdrawn until the issues considered in this review are satisfactorily resolved	***F34.1***	Withdraw advertisement for permanent thoracic consultant	[redacted]	Complete
F35	The Trust should standardise equipment used as far as possible. For example, chest drainage systems should be common.	***F35.1***	Trust will standardise equipment within Theatres/CSICU	[redacted]	Complete
F36	The condition of the paintwork, plasterwork and lighting in the Cardiac Theatre corridors, adjoining rooms and lift areas, should be addressed and a declutter of the area, including notices which appeared to be out of date, should take place	***F36.1***	Condition of building should be addressed. Areas to be decluttered and out-of-date notices to be removed. Repairs to paintwork, plastering and lighting to be undertaken	[redacted]	Complete
F37	The Trust should also investigate the condition of the Cardiac theatres in relatlon to accounts of issues including water leaks, fumes and dust contamination.	***F37.1***	Investigate accounts of issues including water leaks, fumes and dust decontamination	[redacted]	Complete