# Invited Service Review Report

RCS

# Report on the Cardiothoracic Surgical Service

# Belfast Health and Social Care Trust

Review visit carried out on: 9 – 11 March 2020

Report issued: 29 June 2020

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

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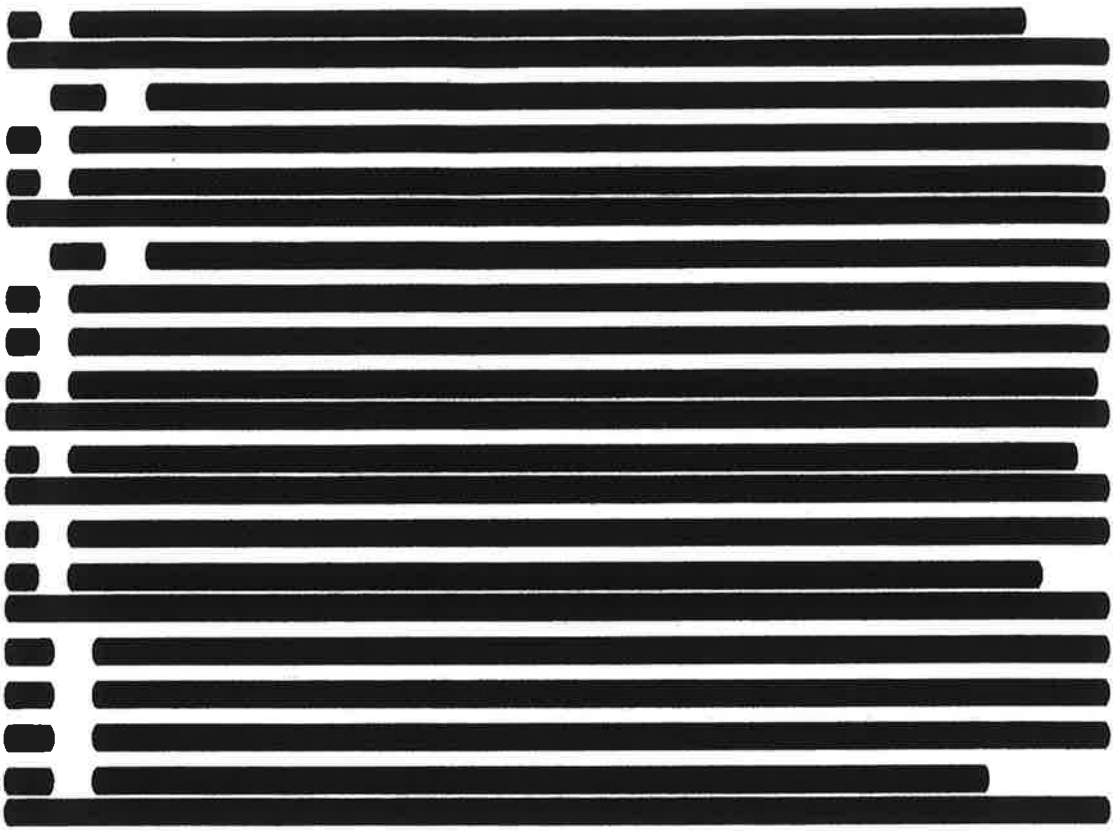

# 1. Introduction and background

On the 27 November 2019, Dr Catherine Jack, Medical Director and Deputy Chief Executive (at time of the request) for Belfast Health and Social Care Trust, wrote to the Chair of the Invited Review Mechanism (IRM) to request an invited service review of the healthcare organisation's cardiothoracic surgical service. In particular, the request highlighted the number of claims and concerns that had been made regarding the clinical management and leadership within the Trust's cardiothoracic surgical service. The concerns included clinical management, and bullying and undermining of consultant colleagues, along with related conflicts of interest. This request was considered by the Chair of the RCS IRM and a representative of the Society for Cardiothoracic Surgeons (SCTS) and it was agreed that an invited service review would take place.

A review team was appointed and an invited review visit was held on 9 – 11 March 2020. The appendices to this report list the members of the review team, the individuals interviewed, the service overview information and the documents provided to the review team.

The review team's conclusions are based on the information provided to them during the interviews held and from the documentation submitted, and are summarised in **Section 3 Conclusions**.

In light of their findings and conclusions, the review team made 24 urgent recommendations that are considered to be highly important actions for the Hospital to take to address risks to patient safety, and 13 recommendations for consideration by the Hospital that were considered important actions to be taken to improve the service. These recommendations are detailed in

Section 4 Recommendations.

Appendix A - summary of information provided to the review team, represents a summary of the information provided to the review team during the interviews held, and in the documentation submitted before, during and after the review visit. Information provided by interviewees during their interviews is presented as it was reported to the review team at the time of their review and circumstances may have changed subsequently. The information presented will sometimes reflect the viewpoints of individual staff members and some viewpoints described may be contradictory or may have been expressed in the absence of further, substantiating information. Noting these viewpoints is not intended to imply their factual accuracy and the information in this section does not necessarily represent the review team's opinions which are summarised in the conclusions section.

## 2. Terms of reference for the review

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

### Background

The review team will consider the standard of care, and clinical management and leadership, provided by the cardiothoracic surgery service, following a request from Cathy Jack, Medical Director and Deputy Chief Executive and Stephen Boyd, Co-Director of Surgery. A number of concerns have been raised regarding the clinical management and leadership within the Trust's cardiothoracic surgery service resulting in a breakdown of communication and working relationships that may have contributed to serious adverse incidents. A number of concerns have also been raised regarding standards of care and trainee well-being within the cardiothoracic surgical service.

### Review

The review will involve:

- Consideration of background documentation regarding the cardiothoracic surgery service including five clinical records and a report of a focus group held with trainees in November 2019.
- Interviews with members of the cardiothoracic surgery service, those working with them to provide the service and other relevant members of the Belfast Health and Social Care Trust staff.

### Terms of Reference

In conducting the review, the review team will consider the standard of care, clinical management and leadership, provided by the cardiothoracic surgery service, including with specific reference to:

- Interpersonal behaviours and communication in the cardiothoracic surgical service between clinicians
- Interactions and communication between the cardiothoracic surgical service management team and clinicians
- Quality of clinical leadership in the cardiothoracic surgical service
- Quality of clinical governance in the cardiothoracic surgical service
- Quality and safety of care delivery including assessment of any clinical outcomes, complications and whether any low, medium or severe harm has occurred
- Development and governance of a modern cardiothoracic surgical service in the Belfast Health and Social Care Trust
- Conflicts of interest within the cardiothoracic surgery service

- Standards of team working including multidisciplinary processes
- Protocols and patient pathways and the application of national standards and guidelines within the cardiothoracic surgical service
- Support provided to trainees and consultant surgeons
- Communication with patients and their relatives
- Highlight areas of good practice
- Identify any other issues of concern noted during the review and report immediately to the Co-Director

**Conclusions and Recommendations**

The review team will, where appropriate:

- Form conclusions as to the standard of care provided by the cardiothoracic surgery service including highlighting good practice and identifying any areas, which require improvement including where national standards or guidelines should be applied.
- Form conclusions about the working relationships within the cardiothoracic surgery service and make recommendations for resolution of any behavioural concerns identified
- Make recommendations for the consideration of the Medical Director and Co-Director of Surgery of Belfast Health and Social Care Trust as to courses of action which may be taken to address any specific areas of concern which have been identified or otherwise improve patient care.

# 3. Conclusions

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

## 3.1. Interactions and communication between the cardiothoracic surgical service management team and clinicians

The review team concluded that interpersonal and behavioural issues in the cardiothoracic surgical service ultimately pointed to problems in leadership and management responsibilities at departmental and senior levels, and a lack of support for the cardiothoracic surgical team from its leadership at all levels over a prolonged period. The review team considered that the values and culture of management and its leadership style required review and reflection. There appeared to be a top-down management style in the Trust which was not open or transparent and did not involve consensual buy-in from the whole team. This needs to be improved so that the surgical team's wellbeing is prioritised, which, ultimately, will lead to improvements in patient care.

Feedback from the majority of the surgical team was critical in relation to interaction and communication between the cardiothoracic surgical service management team and clinicians. There were views expressed that issues in the unit were down to the management structure, which was said to be vertical and hierarchical, and that the only link between the surgical team and Hospital management was the Clinical Director, which was not a satisfactory situation. Some consultant surgeons described feeling undervalued by management. There were allegations of management team meeting minutes being altered after the fact and of resistance to adverse patient outcomes being raised as Serious Adverse Incidents (SAI). There were reports that management, from the highest level, stifled innovations, which it was suggested had then led to risk-averse practise and that business cases were 'blocked'.

There were views that, as the surgical consultant group contained individuals who were described variously as having 'big' and 'challenging' personalities, managing the group was challenging and required careful management.

### 3.1.1. Senior Management

Although not specifically within the terms of reference, a number of views were raised in relation to senior management in the Trust, and the review team considered it important to include them as they affect the service as a whole. As described in section 3.1. the review team considered that the values and culture of senior management have not benefited the cardiothoracic service and have exacerbated issues in the service.

Staff at all levels, including non-clinical roles, who were interviewed cited a lack of interest and support, and a lack of transparency, from management as an issue.

A number of interviewees raised concerns in relation to investigatory processes in the Trust, which were variously described as 'heavy handed', drawn out and disproportionate.

[redacted]

## 3.2. Quality of clinical leadership in the cardiothoracic surgical service

[redacted]

[redacted] The review team heard that appointment of Clinical Directors was for a three-year term, subject to satisfactory review. There was no limit to the number of terms an individual can serve, but serving Clinical Directors are required to reapply for the role through competitive recruitment, including an interview.

[redacted]

The review team considered that there had been improvements made to the service. However, a number of issues of concern regarding clinical leadership appear to have been allowed to continue unchecked for a number of years.

[redacted] The review team considered that succession planning for a substantive Clinical Director, should be a priority.

It was also concluded that clinical lead roles, for cardiac and thoracic surgery, should be re-established, a suggestion the review team would support.

The review team also considered that Service Managers should have more oversight of, and management responsibility for, interpersonal issues in the service, as this was not necessarily the case at the time of the review visit.

## 3.3. Interpersonal behaviours and communication in the cardiothoracic surgical service between clinicians

The review team considered that there was a culture of fear, paranoia and an undercurrent of bullying within the cardiothoracic service. The service was described by some interviewees as being a 'dysfunctional', 'horrible', 'hostile', and 'toxic' environment to work in. This had negatively impacted on surgical colleagues and staff, both professionally and personally and had filtered down to nursing and other non-surgical members of the wider multidisciplinary team (MDT). The review team were particularly concerned to hear reports of alleged racial discrimination and abuse which they considered wholly unacceptable.

The review team considered there were two main 'groups' within the consultant surgeon team, and that interpersonal relationships between the two 'groups', and between individuals, had progressively worsened resulting in a breakdown of communication.

There were various reasons put forward for these interpersonal difficulties which appear to have developed over a number of years but were reported to have significantly worsened over the past year. These included rivalries between cardiac and thoracic surgeons, exacerbated by sharing a ward, mixed practice, private practice, 'money issues' and 'narcissistic personalities'. [redacted]

[redacted]

The review team were provided with reports of multiple internal complaints, accusations and counter-accusations between members of the surgical team. There was a general perception that a large number of complaints and issues were spurious, and were being raised as a cover for personal issues, and in some cases were orchestrated to discredit particular individuals. The review team were not in a position to draw conclusions in relation to individual complaints raised but considered that this situation was damaging to the service as a whole, to the individuals concerned and, potentially, to patients.

Nevertheless, despite all of these issues, the consultant team was described as patient centred and focused on providing good patient care, and the review team were persuaded that the majority of staff interviewed were passionate about providing good patient care

However, the review team concluded that if the current situation persists, these interpersonal issues could result in members of the cardiothoracic surgery consultant team leaving the Hospital.

The review team considered that the whole consultant team should learn, understand and put in to practice 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; 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 sanctions if unacceptable behaviour persists.

The review team wished to emphasise that all consultant surgeons are 'leaders' in the service, and have a responsibility to lead by example. This is a fundamental point that is key to any future change. Failures in leadership described in this report have not been solely limited to directors, including Clinical Director, and higher level positions; it includes members of the consultant cardiothoracic surgical team as well.

### 3.3.1. Waiting List Initiatives and Private Practice

The review team heard that NHS work was being outsourced to private hospitals and had been a source of tension in the service.

The review team considered that waiting times, particularly those for lung cancer, were unacceptably long, and were poor for a regional service. It was widely reported that weekend operating could alleviate long waiting times, and a number of staff were in favour of this. However there were a number of reasons cited why weekend operating had not taken off, including remuneration and conflicting professional and personal commitments.

Private practice in the Hospital had been undertaken in the past but this had been stopped recently. The review team heard conflicting accounts of why this had happened, and whether

this was specialty specific or hospital wide and this was reported to be another source of tension in the service.

[redacted]

## 3.4. Conflicts of interest within the cardiothoracic surgery service

[redacted]

## 3.5. Quality of clinical governance in the cardiothoracic surgical service

The review team were informed that the cardiothoracic service was a regional centre within Northern Ireland and was benchmarked against four other Trusts. In terms of data, the Trust had gone above what the region required however the review team considered that the benchmarking of the service could be improved with better systems in place.

The review team were concerned to hear that personal disagreements, unrelated to patient care, were sometimes aired at audit meetings which made some attendees uncomfortable. This appeared to go back to the reported interpersonal issues and the review team considered that all

governance meetings should remain professional with discussions focused on relevant issues, and not interpersonal matters.

The review team heard that mixed-practice surgeons did not attend thoracic meetings and considered that mixed-practice surgeons, for the period in which mixed-practice is in place in the service, should attend all meetings. Consultant and management meetings should be formally timetabled in job plans outside of elective clinical working time.

Examples of restricting practice were reported to the review team. The review team were concerned that restrictions on practice described did not appear to be led by data or any extant policy, but as reported to the team appeared arbitrary and unprofessional without it being clear what the factual or evidential basis for this was. Restrictions on individual surgeons' practice should always be supported by robust evidence and data and adequate governance for monitoring and auditing procedures should be in place.

## 3.6. Quality and safety of care delivery including assessment of any clinical outcomes, complications and whether any low, medium or severe harm has occurred

Notwithstanding the interpersonal issues in the service, the review team heard largely positive views on the standards of patient care and outcomes, for example NICOR[1] outcomes data (2015-2018). The review team did not have any immediate concerns that the cardiothoracic surgery service, for those who receive the service, was not generally safe for patients.

Despite the failings in leadership and interpersonal relationships, the overall impression was of a team that was achieving good surgical outcomes.

However, as with any surgical service, there were reported to have been adverse incidents. The review team were provided with anecdotal accounts of incidents but were not in the position to consider these further or come to any conclusions about these circumstances during their review visit.

As a result of changes to interview timings for the invited review visit, the review team were unable to carry out a review of the five clinical records. The review team have therefore made a recommendation that the Trust consider commissioning a separate clinical record review with particular specialist thoracic surgery input.

The review team considered that unacceptably long lung cancer waiting lists and delays in the service were a major concern. The 62-day target was not being met. The review team concluded that patients may be coming to harm during this extended waiting period and understood that a number of serious incident reports had been raised in relation to cancer delays. Limiting steps/factors in the patient pathway were described as including access to theatre, diagnostics, MDT and the availability of PET[2] scanning. The recruitment and retention of nursing staff had also been difficult. There were views that this was a regional issue with delays not limited to the Trust, but also present in other Trusts in the region. Whatever the cause the review team considered that this was something that needed to be addressed.

The review team considered there were concerns over patients, who should have had lobectomy for lung cancer, undergoing wedge resections instead, and then re-presenting with early local recurrence. The review team made recommendations that the Trust should audit all patients who

[1] National Institute for Cardiovascular Outcomes Research
[2] Positron emission tomography

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.

Outcomes, including mortality rates, from VATS [3]lobectomies were reported by clinicians interviewed as good and the review team heard there was a quick journey through the pathway. The number of VATs lobectomies have increased in the past few years and there were views that they should be the default position for patients where possible. However, the fact that not all members of the consultant team perform VATs lobectomies appeared to be a source of conflict in the service, and this was putting patients who did not have the procedure using this technology at a disadvantage. It was reported that VATS lobectomies had been adopted in different ways by different people [redacted]

The review team recommended the establishment of a scheduling meeting for lung cancer surgery so that those patients suitable for VATs lobectomy are identified and offered the procedure.

The review team advised that the Trust's surgeons, and medical and clinical directors, should refer to the Royal College of Surgeons of England's 'Surgical Innovation, New Techniques and Technologies; A Guide to Good Practice'[4] guidance when introducing innovative techniques and/or technology into surgical services.

## 3.7. Development and governance of a modern cardiothoracic surgical service in the Belfast Health and Social Care Trust

The review team heard views that the Hospital was driven by the emergency department and acute emergency care and that specialised services were overlooked. Elective cases were sometimes cancelled in favour of emergency cases; however, it was rare that cases were cancelled as a result of staff shortages

The review team heard views in relation to the Cardiac ICU that as Cardiac ICU outcomes were satisfactory there was no desire to improve it or effect change, and it was not a priority for the service. However, a number of concerns were raised in relation to Cardiac ICU having staff shortages, a lack of protected beds and outdated IT systems. A number of interviewees mentioned that Cardiac ICU did not have a dedicated pharmacist. The review team considered that all patient management in Cardiac ICU should be channelled through the intensivists.

The review team were provided with descriptions of the cardiac theatres, and communal areas such as corridors, and were informed that the cardiac theatres were meant to have been moved to a more modern building but that this had been put on hold. The review team visited the cardiac theatre corridors, adjoining rooms and lift areas and concluded that the appearance was not in line with their expectations of a modern cardiac surgery service. The review team concluded that the existing premises need to be refurbished whilst awaiting the move to new premises. The review team did not visit the cardiac theatre but were concerned by accounts of issues such as water leaks, fumes, and, in one case, [redacted] and concluded that the hospital look into the condition of the cardiac theatre further.

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[3] Video-Assisted Thoracic Surgery

[4] https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/surgical-innovation/

At the time of the visit there were a large number of nursing vacancies in the cardiothoracic service and a shortage of nurses across the Trust generally. The review team understood that there was a large recruitment drive recently, and an intake of new nurses in the service in the six months prior to the review visit, particularly for the cardiac theatre. However, nurses were continuing to leave the service in large numbers. The review team considered that rapid turnover of staff in any service is detrimental and noted a view that was reported that there had been a deterioration in the skill of nurses. It was also the case that the majority of interviewees praised the dedication of the nursing staff in the service.

### 3.7.1. Mixed Practice

The review team heard diverse views on the strengths and weaknesses of mixed cardiothoracic practice, and of having dedicated cardiac and thoracic surgeons. Some thought that mixed practice was too much for surgeons to learn and keep up with, and it was alleged that some surgeons were practising out of date thoracic surgery. Others considered that mixed practice could impact adversely on cardiac patients. There were views that separating Cardiac and Thoracic surgery, with Clinical Directors for each separate team, would be beneficial. Some interviewees considered that some consultant surgeons were protecting mixed practice in their own personal interest.

There were fears that the thoracic service currently was too small to stand on its own and if the teams were to be split additional thoracic surgeons would need to be recruited and additional theatres opened. There were also questions over what would happen to trainees in these circumstances, and a view was expressed that cardiac and thoracic training should be separate, as training in both disciplines was too specialised.

The review team considered that for an optimal modern service, best practice would be to separate cardiac and thoracic surgery with surgeons dedicated to either cardiac or thoracic surgery, including on-call arrangements.

### 3.7.2. Cardiac and thoracic ward merger

The cardiac and thoracic wards were merged into one cardiothoracic ward in 2015. There were differing accounts of who was responsible for the decision, however most staff interviewed were of the view that the wider consultant surgical team and nursing staff were not involved in discussions or decisions to merge the ward, and that consultant surgeons as a whole did not accept the merger and considered they were competing with each other for beds and resources. It was suggested that the merger had also caused anxiety for nursing staff. Nursing staff were reportedly provided with only two weeks' notice of the merger and some staff had to re-interview for posts. Nursing staff had to learn both cardiac and thoracic specialties after the ward merger and interviewees praised nurses for working hard to upskill and integrating well.

## 3.8. Standards of team working including multidisciplinary processes

The review team interviewed a range of staff in the surgical and wider multidisciplinary team at the hospital and other regional Trusts.

The review team considered that MDT meetings and processes in the service were well established and consultant surgeons from the Trust had established connections with colleagues from other Trusts in the region, and attended regional MDT meetings. Communication could be variable however and there were concerns raised around weaknesses with consensus, debate and discussing risk.

There could be issues with cardiologists getting consultant surgeons to take ownership of inpatients who require surgery and delays with patients waiting for redo operations as there was reported to be an "unofficial" policy that the original operating surgeons had to carry out the redo

operation. There were views that cardiac surgeons, anaesthetists and cardiologists should be working more closely together. The review team concluded that the Trust needed to develop clear responsibilities for out of hours cover.

It was reported to the review team that there was very little cross-specialty communication and silo working was common in the hospital

### 3.8.1. Working relationships between surgeons and anaesthetists

There were mixed reports about working relationships between surgeons and anaesthetists, with some reports of bullying and undermining behaviour towards anaesthetists by some surgeons. Other views were expressed that behaviour and communication between surgeons and anaesthetists was, by and large, professional and staff were well behaved, and acted in the patient interest. [redacted] which the review team where unable to look into further or substantiate, due to a lack of further information being provided but is reported here as an example of the range of feedback provided

The review team considered that, as with interpersonal relationships between the surgical team, professional relationships between surgeons and anaesthetists should be professional and mutually respectful.

Responsibility for decision-making on the Intensive Care Unit was identified as a source of dispute between surgeons and anaesthetists and there were views raised with the review team that there was a lack of clarity over this. The review team considered that all clinical management decisions should be channelled through the ICU consultant.

At the time of the review visit, cardiac anaesthetists sat outside of general ICU. Varying views were expressed on where cardiac anaesthetists should sit in the Trust; some that cardiac anaesthetists should sit with the cardiac surgery service, and others that supported links with ICU as being in the wider interest of the service as it supported shared knowledge and learning for the benefit of patient care.

### 3.8.2. Working relationships between surgeons and nursing staff

The review team noted that nursing staff in the service were widely praised as being highly professional, but they also recognised that nurses had suffered the effects of the reported interpersonal issues between consultants, and were often caught between surgeons and other members of the team on specific issues. It was reported to the review team that nurses have been subjected to direct undermining and bullying behaviour from consultants and trainee surgeons. As with negative interpersonal behaviour between the surgical team, the review team concluded that this negative behaviour should stop.

## 3.9. Protocols and patient pathways and the application of national standards and guidelines within the cardiothoracic surgical service

### 3.9.1. Morning briefings, WHO checklists and post-operative protocols.

The review team heard conflicting reports about attendance at the daily 8.00 a.m. theatre briefing in the Thoracic and Cardiac theatres. Surgical registrars were usually present when patients were being anaesthetised, however the attendance of consultant surgeons was said to be variable, with some consultant surgeons reportedly not always present in the Hospital at the start of cases, which is unacceptable. The review team concluded that the whole theatre team, including consultants, must be present at the briefings.

It was reported that adapted WHO checklists were utilised prior to operations commencing, however it was suggested that consultants were not always present and a re-brief on the checklist had to be done when the surgeon arrives for the operation. Again, the review team consider this unacceptable. The review team concluded that during the completion of the WHO checklist, consultants should be present on every occasion.

The review team were informed that there was not an end of day debrief with surgeons always present; debriefs took place if there was an adverse incident but, reportedly, even these did not always take place at the end of the day but when staff "get together". The review team were of the opinion that there should be an end of day debrief after each case, with the operating surgeon present.

The review team concluded that post-operative procedures were not adequately standardised. They specifically concluded 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, and have made recommendations to this effect.

### 3.9.2. Ward Rounds

The review team heard there were separate thoracic and cardiac ward rounds every morning at 8:00 and 9:00 am respectively. It was reported that consultant surgeons were not always present for ward rounds however surgical registrars were present, and there were differing opinions on this, with some advocating that this was good development for learning how to assess people, and develop decision making skills, and others concerned that decisions were being made by inexperienced registrars.

It was reported that 'Consultant of the Week' had been trialled but not continued. The review team concluded that this should be re-established and would rectify the issues set out above.

### 3.9.3. Friday 'Grand Rounds'.

The review team were advised that every Friday there was a 'grand round' on ward 5A, including all grades of surgeons which can include up to ten to fifteen people.

The review team heard reports of challenging, undermining and unprofessional behaviour on the Friday 'grand round', often in front of patients. The review team concluded that the 'grand round' is unnecessarily large, cumbersome and can be intimidating for patients. This practice was considered unacceptable and it was the review team's view that the Friday 'grand round' should be stopped. The review team considered that the 'grand round' should be replaced with appropriate multi-disciplinary teaching, in a constructive environment, which does not impact negatively on patients and is a constructive learning experience for all who attend.

## 3.10. Support provided to trainees and consultant surgeons

*Surgical 'trainees' in the cardiothoracic service is a term that can include all non-consultant grades including Foundation and Core trainees, Specialty Registrars (StRs), and Clinical Fellows.*

The review team were provided with the report of a focus group that was held with [redacted] trainees, including [redacted], in November 2019, and associated documentation.

The report of the focus group concluded that:

*'Trainees have reported a largely positive training experience in RVH Cardiothoracic Unit, which has left them competitive for Consultant applications in the UK, where appropriate post-CCT. Most consultants are described as excellent trainers and are supportive of trainees. However, trainees have reported that there has been a pattern of repetitive undermining behaviour demonstrated*

*against a range of NHS staff, particularly trainees, over many years for which a small number of consultants are responsible. A number of patient safety issues have been detailed in previous correspondence to the Medical Director's office. Trainees did not report any further examples at the meeting where they identified that patient safety was at risk'.*

During the course of their visit the review team heard positive views from current trainees in relation to the trainee experience and support given. It was said that surgical trainees received a very good training experience in the Hospital, there were firm structures in place and a good training environment. Consultant surgeons generally were approachable and supportive of trainees, however this could vary. Wider members of the team, such as anaesthetists, specialty doctors and nurses, were approachable.

However, the review team heard that there was a problem with retention once the trainees had completed their training. There were views that the unit had a reputation amongst trainees as not being a 'nice place to work' and that they did not stay because of interpersonal issues in the service. Alternatively, it was put forward that there was a regional issue with trainees not staying in Northern Ireland, and this was not exclusively a local issue.

The review team considered that there was an undercurrent of undermining and bullying of trainees and locum surgeons over a number of years. This was described by some as part of an accepted culture, and may have negatively impacted on what was, by most accounts, a positive training environment in terms of operative experience.

The review team considered that out of hours on-call cover from consultant surgeons was not clearly defined and have recommended that the Trust develop clear responsibilities for out of hours cover for inpatients from consultant surgeons.

## 3.11. Communication with patients and their relatives

The review team were provided with largely positive feedback from interviewees in relation to communication with patients and their relatives, with interactions between clinicians and patients being described as generally constructive, professional and of high quality. Patients were described by interviewees as generally well informed and know the treating consultant. By most accounts, the interpersonal issues affecting the team do not filter down to patients, the notable exception being the Friday 'Grand Ward Round', which is covered in section 3.9.3. 'Friday 'Grand Rounds'.

It was reported that there was no standardised template for patient correspondence and each consultant had their own format.

Patient complaints in the cardiothoracic service were reported to be relatively low and there were no specific outliers identified in complaints relating to the service.

## 3.12. Highlight areas of good practice

The review team were asked to highlight areas of good practice in the service. The following is a summary of information provided by staff interviewed.

It was reported that:

- Clinical outcomes were good and have improved over the past few years. Infection rates have improved.

- The hospital had good outcomes on NICOR[5] (2015-2018) and was performing in line with other services in the UK.
- The service now has navigational bronchoscopy[6], reportedly the only service in the island of Ireland to have this.
- There had been a growth in the use of TAVI[7] in the service.
- Nursing staff were praised as being highly professional with good patient feedback received.
- The goodwill of nursing staff was described as 'phenomenal'.
- The theatre and ICU teams were praised as being very professional.

The review team considered that the Specialist Nurse roles were innovative in the service and noted that a number of positive developments had been made including creating information leaflets and discharge advice, and providing personal interaction and advice for patients attending for surgery including returning patients.

## 3.13. Identify any other issues of concern noted during the review and report immediately to the Co-Director

Other than issues raised in relation to senior management which is covered in **section 3.2.1**., the review team identified one issue of concern which was outside of the terms of reference, and which was reported back to the Hospital confidentially.

[5] National Institute for Cardiovascular Outcomes Research
[6] Electromagnetic navigation bronchoscopy (ENB) is a relatively new way of obtaining lung biopsies using electromagnetic waves.
[7] Transcatheter aortic valve implantation (TAVI) is a less invasive procedure that is designed to replace a diseased aortic valve.

# 4. Recommendations

## 4.1. Urgent recommendations to address patient safety risks

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

1. 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.

2. Interactions and communication between the cardiothoracic surgical service management team and clinicians should be reviewed and improved.

3. Coaching for managers and leaders should be considered in order to facilitate continuing improvement in management/leadership skills and values.

4. A system should be put in place where senior line management formally appraise Clinical Directors at appropriate intervals, ideally on a quarterly basis.

5. 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.

6. If necessary, external facilitation should be considered to assist with addressing and rectifying interpersonal issues.

7. 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.

8. 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.

9. Restrictions on individual 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.

10. 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.

11. 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.

12. Innovative waiting list initiatives should be considered, including, where possible, weekend operating.

13. 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.

14. 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.

15. In the Cardiac ICU all patient management should, from now on, be channelled through the intensivists.

16. The whole theatre team, including consultant surgeons, must be present at the 8:00 a.m. daily theatre briefings.

17. During the completion of the WHO checklist, consultants should always be present on every occasion.

18. There should be an end of day debrief with the operating surgeon present.

19. 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.

20. The Trust should develop clear responsibilities for out of hours cover for inpatients from the consultant surgeons.

21. 'Consultant of the Week' should be re-established.

22. All locum surgeons should be provided with job plans.

23. 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.

24. 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.

## 4.2. Recommendations for service improvement

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

25. [redacted]

26. Inconsistencies with the status of private practice in the service, which has been a source of tension, should be addressed by the Trust.

27. Succession planning for a substantive Clinical Director of the cardiothoracic service should be a priority for the Trust.

28. Clinical Lead Roles in the service should be re-established.

29. The Trust should reconfigure its consultant workforce so all consultant surgeons practice exclusively either cardiac or thoracic surgery, including on call arrangements.

30. For the period in which mixed-practice is in place, mixed-practice surgeons should attend all meetings, including thoracic meetings, as required.

31. Consultant and management meetings should be formally timetabled in job plans outside of elective clinical working time.

32. The Trust should review the IT system on ICU and consider a dedicated pharmacist in Cardiac ICU.

33. 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.

34. The advertisement for the permanent thoracic consultant post should be withdrawn until the issues considered in this review are satisfactorily resolved.

35. The Trust should standardise equipment used as far as possible. For example, chest drainage systems should be common.

36. 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.

37. The Trust should also investigate the condition of the Cardiac theatres in relation to accounts of issues including water leaks, fumes and dust contamination.

## 4.3. Responsibilities in relation to this report

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

It is also the responsibility of the healthcare organisation to review the content of this report and in the light of these contents take any action that is considered appropriate to protect patient safety and ensure that patients have received communication in line with the responsibilities set out in the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Regulation 20.[8]

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

## 4.4. Further contact with the Royal College of Surgeons

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

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

# Appendix C – Service overview information

Prior to the review visit the healthcare organisation was asked to complete the following 'service overview form'. The information presented below is what was provided.

| | Number | Additional notes |
|---|---|---|
| **Local information** | | |
| Catchment population | 1,810,863 | Regional services to Northern Ireland Population |
| Sites providing specialty service | | Regional center for inpatient surgery and outpatient assessment based at Royal Victoria Hospital. Other regional hospital provide diagnostic services. |
| **Personnel numbers** | | |
| Consultant Surgeons within specialty service | 11 | Substantive Cardiac – [redacted]<br>Locum Cardiac – [redacted]<br>Substantive Thoracic – [redacted]<br>Substantive Cardiothoracic – [redacted] |
| Surgeons within wider team | 0 | Surgical support from other services in Belfast Trust as required. |
| Surgical registrar posts | 11 | Clinical Fellow – 3<br>ST3+ - 5<br>LAS - 3 |
| Junior doctors supporting the service | 12 | FY1 – 2<br>FY2 – 3<br>Core Trainees – 6<br>ST1 - 1 |
| **Details of on-call** | | |
| Consultant surgeon on-call | 1 in 8 | Cardiothoracic surgeons cover both specialties when on call |
| Surgical registrar on-call | 1 in 11 | |
| **Facilities** | | |
| Service dedicated ward beds | 32 | |
| ICU beds | 11 | |
| HDU beds | 8 | |
| Theatres used by the service | 6 | 3 dedicated cardiac theatres<br>3 thoracic theatres (none dedicated) |
| Inpatient elective lists per week | 39 | 26 Cardiac |

| | | |
|---|---|---|
| | | 11 Thoracic |
| Day case elective lists per week | 2 | Both thoracic |
| Emergency lists per week | 0 | None dedicated. Thoracic access to emergency theatre for multiple specialties. Cardiac use own theatres for emergencies as required. |
| New patient clinics per week | 11 | New and Review patients seen at same clinic. |
| Follow up clinics per week | 11 | New and Review patients seen at same clinic. |

**Activity numbers per year for the past two years**

| | |
|---|---|
| Outpatients seen | Thoracic FY 2017/18 – 1976 |
| | Thoracic FY 2018/19 – 1812 |
| | Cardiac FY 2017/18 – 2955 |
| | Cardiac FY 2018/19 - 2395 |
| Acute admissions | Thoracic FY 2017/18 – 203 |
| | Thoracic FY 2018/19 – 208 |
| | Cardiac FY 2017/18 – 42 |
| | Cardiac FY 2018/19 - 26 |
| Elective admissions | Thoracic FY 2017/18 – 744 |
| | Thoracic FY 2018/19 – 686 |
| | Cardiac FY 2017/18 – 892 |
| | Cardiac FY 2018/19 – 760 |
| Number of patients undergoing surgery | <u>Emergency</u> |
| | Thoracic FY 2017/18 – 8 |
| | Thoracic FY 2018/19 – 20 |
| | Cardiac FY 2017/18 – 21 |
| | Cardiac FY 2018/19 - 32 |
| | <u>Inpatient</u> |
| | Thoracic FY 2017/18 – 740 |
| | Thoracic FY 2018/19 – 638 |
| | Cardiac FY 2017/18 – 859 |
| | Cardiac FY 2018/19 - 740 |
| | <u>Daycase</u> |
| | Thoracic FY 2017/18 – 16 |
| | Thoracic FY 2018/19 – 70 |
| | Cardiac FY 2017/18 – 0 |
| | Cardiac FY 2018/19 - 0 |

| | | |
|---|---|---|
| 18 week breaches | | **Cardiac Surgery – 'Cardiology Inpatients' (7 working day target**<br>FY 2017/18 Breaches - 160<br>FY 2018/19 Breaches - 142<br>**Cardiac Surgery – Elective Patients (13 week target)**<br>FY 2017/18 Breaches - 314<br>FY 2018/19 Breaches – 263<br>**Thoracic Surgery – Cancer Patients (31 day target)**<br>FY 2017/18 Breaches - 63<br>FY 2018/19 Breaches - 97<br>**Thoracic Surgery – Elective Patients (13 week target)**<br>FY 2017/18 Breaches - 182<br>FY 2018/19 Breaches - 193 |
| Patients on elective waiting list | | As at December 2019:<br>Cardiac – 186<br>Thoracic – 356 |

**Clinical governance arrangement for the past two years**

| | | |
|---|---|---|
| MDT meeting frequency | Weekly | Weekly acquired Cardiac MDT x 4, TAVI MDT, Congenital MDT and Mitral MDT<br>Weekly Lung MDM's held x 5 (1 for each Trust in region) |
| Time scheduled for MDTs | 1 – 2 hours | Varying dependent on volume of cases discussed |
| Average consultant surgeon MDT attendance (%) | 2 surgeons at each MDT | Included in all job plans |
| M&M meeting frequency | Monthly | Held on regional audit day each month |
| Time scheduled for M&M | 1 hour | Between 5 and 10 cases discussed |
| Average consultant surgeon M&M attendance (%) | 75% | No clinical commitments scheduled. Expected 75% attendance to take account of leave. |
| Number of audit days last year | 12 | Monthly |
| Time scheduled for audit days | Half day | |

| | | |
|---|---|---|
| Other regular governance meetings | | Ward Governance Meeting – Weekly<br>CSICU Operational Group – Monthly<br>Surgeons Meeting – Fortnightly<br>Management/Clinical Lead Meeting – Fortnightly<br>Management Team Governance Meeting – Fortnightly<br>Divisional Safety and Quality Meeting – Monthly<br>Directorate Senior Management Team - Monthly |
| National databases submitted to | | NICOR – National Institute for Cardiovascular Outcomes Research<br>CCAD – Cardiac Congenital Audit Database<br>SCTS – Society for Cardiothoracic Surgery |

**Complaints, incident reporting and SUIs in the last two years**

| | | |
|---|---|---|
| Number of incidents | | Cardiac FY 2017/18 & FY 2018/19<br>Insignificant – 109<br>Minor – 164<br>Moderate – 42<br>Major – 5<br>Catastrophic - 12<br>Thoracic FY 2017/18 & FY 2018/19<br>Insignificant – 81<br>Minor – 71<br>Moderate – 15<br>Major – 7<br>Catastrophic - 4 |
| Number of SUIs | 7 | Thoracic x 1 – RCS undertaking note review<br>Cardiac x 6<br>1. One action remaining to progress<br>2. Action plan being progressed<br>3. Service progressing report<br>4. Draft report with service<br>5. RCA investigation led by InPractice<br>RCA Investigation led by InPractice |
| Number of patient complaints | | Cardiac FY 2017/18 & FY 2018/19<br>Low – 22<br>Medium – 3<br>High – 0 |

| | | |
|---|---|---|
| | | Thoracic FY 2017/18 & FY 2018/19 |
| | | Low – 22 |
| | | Medium – 0 |
| | | High – 1 |
| Number of never events | 0 | None reported in last 2 years |

# Appendix D – Documents received during the review

The following items of documentation were provided to the review team before, during or after the review visit. It is requested that the healthcare organisation responsible for commissioning the review retains a copy of all items of documentation for its own records, and to be in a position to make it available on request and to comply with information access requests. Once the RCS issues the report, it will not keep a copy of this information indefinitely.

- Report of the Focus Group held with trainees in Nov '19
  - 1.0a – Focus Group with Cardiothoracic Trainees 2019
  - 1.0b - TA Outlier Post Spec by Site - Cardiothoracic 2019
  - 1.0c - TA Outlier Prog Group by Site - CST + Cardiothoracic 2019
- Consultant Job Plans
  - 2.0a - [redacted] - JP - 1.4.18 - 31.3.19
  - 2.0b - [redacted] - JP - 1.1.19 - 31.3.19
  - 2.0c - [redacted] - JP - 1.4.17 - 31.3.18
  - 2.0d - [redacted] - JP - 1.8.18 - 31.3.19
  - 2.0e - [redacted] - JP - 1.6.18 - 31.7.19
  - 2.0f - [redacted] - JP - 1.1.19 - 31.3.20
  - 2.0g - [redacted] JP - 1.11.18 - 31.3.19
  - 2.0h - [redacted] - JP - 1.11.18 - 31.3.19
  - 2.0i - [redacted] JP - 1.4.18 - 31.3.19
  - 2.0j - [redacted] - JP - 1.4.18 - 31.1.19
- Minutes of Morbidity and Mortality and Multidisciplinary meeting and log od M&M meetings
  - 3.0a – Thoracic M&M 18.04.19
  - 3.0b – Thoracic M&M 16.05.19
  - 3.0c – Thoracic M&M 19.07.19
  - 3.0d – Thoracic M&M 13.08.19
  - 3.0e – Thoracic M&M 17.09.19
  - 3.0f – Thoracic M&M 16.10.19
  - 3.0g – Thoracic M&M 16.01.20
  - 3.0h – Cardiac M&M 18.04.19
  - 3.0i – Cardiac M&M 16.05.19
  - 3.0j – Cardiac M&M 14.06.19
  - 3.0k – Cardiac M&M 19.07.19
  - 3.0l – Cardiac M&M 13.08.19
  - 3.0m – Cardiac M&M 17.09.19
  - 3.0n – Cardiac M&M 16.10.19
  - 3.0o – Cardiac M&M 13.11.19
  - 3.0p – Cardiac M&M 12.12.19
  - 3.0q – Cardiac M&M 16.01.20
- Waiting List
  - 4.0a – Waiting List Information
- Ward Governance Meeting – Weekly
  - 5.0a – Ward Governance Meeting Minutes 05.04.19
  - 5.0b – Ward Governance Meeting Minutes 12.04.19
  - 5.0c – Ward Governance Meeting Minutes 26.04.19
  - 5.0d – Ward Governance Meeting Minutes 31.05.19
  - 5.0e – Ward Governance Meeting Minutes 24.05.19
  - 5.0f – Ward Governance Meeting Minutes 31.05.19
  - 5.0g – Ward Governance Meeting Minutes 07.06.19
  - 5.0h – Ward Governance Meeting Minutes 21.06.19

- 5.0i – Ward Governance Meeting Minutes 28.06.19
- 5.0j – Ward Governance Meeting Minutes 05.07.19
- 5.0k – Ward Governance Meeting Minutes 26.07.19
- 5.0l – Ward Governance Meeting Minutes 02.08.19
- 5.0m – Ward Governance Meeting Minutes 09.08.19
- 5.0n – Ward Governance Meeting Minutes 30.08.19
- 5.0o – Ward Governance Meeting Minutes 06.09.19
- 5.0p – Ward Governance Meeting Minutes 13.09.19
- 5.0q – Ward Governance Meeting Minutes 27.09.19
- 5.0r – Ward Governance Meeting Minutes 04.10.19
- 5.0s – Ward Governance Meeting Minutes 11.10.19
- 5.0t – Ward Governance Meeting Minutes 25.10.19
- 5.0u – Ward Governance Meeting Minutes 08.11.19
- 5.0v – Ward Governance Meeting Minutes 22.11.19
- 5.0w – Ward Governance Meeting Minutes 29.11.19
- 5.0x – Ward Governance Meeting Minutes 06.12.19
- 5.0y – Ward Governance Meeting Minutes 24.01.19
- 5.0z – Ward Governance Meeting Minutes 31.01.19

- CSICU Operational Group – Monthly
  - 6.0a – CCOG Minutes 29.04.19
  - 6.0b- CCOG Minutes 03.06.19
  - 6.0c – CCOG Minutes 07.10.19
  - 6.0d – CCOG Minutes 07.10.19
  - 6.0e - CCOG Minutes 04.11.19
  - 6.0f - CCOG Minutes 06.01.20
  - 6.0g - CCOG Minutes 03.02.20
- Surgeons Meeting – Fortnightly
  - 7.0a – Surgeons Meeting Minutes 09.01.19
  - 7.0b – Surgeons Meeting Minutes 23.01.19
  - 7.0c – Surgeons Meeting Minutes 06.02.19
  - 7.0d – Surgeons Meeting Minutes 13.02.20
  - 7.0e – Surgeons Meeting Minutes 20.02.19
  - 7.0f – Surgeons Meeting Minutes 27.03.19
  - 7.0g – Surgeons Meeting Minutes 17.04.19
  - 7.0h – Surgeons Meeting Minutes 15.05.19
  - 7.0i – Surgeons Meeting Minutes 05.06.19
  - 7.0j – Surgeons Meeting Minutes 26.06.19
  - 7.0k – Surgeons Meeting Minutes 14.08.19
  - 7.0l – Surgeons Meeting Minutes 11.09.19
  - 7.0m – Surgeons Meeting Minutes 02.10.19
  - 7.0n – Surgeons Meeting Minutes 30.10.19
  - 7.0o – Surgeons Meeting Minutes 27.11.19
  - 7.0p – Surgeons Meeting Minutes 09.01.20 DRAFT
- Management – Clinical Leads Meeting – Fortnightly
  - 8.0a - Management.Clinical Lead Meeting Minutes 10.10.19
  - 8.0b - Management.Clinical Lead Meeting Minutes 24.10.19
  - 8.0c - Management.Clinical Lead Meeting Minutes 02.01.20
  - 8.0d – Pre-Audit Cardiothoracic Management Meeting Minutes 09.08.19
  - 8.0f - Pre-Audit Cardiothoracic Management Meeting Minutes 16.10.19
  - 8.0g - Pre-Audit Cardiothoracic Management Meeting Minutes 16.01.20
  - 8.0h - Pre-Audit Cardiothoracic Management Meeting Minutes 14.02.20
- Management Team Governance Meeting – Fortnightly
  - 9.0a – Specialist Surgery Governance SAI Minutes 03.06.19
  - 9.0b – Specialist Surgery Governance SAI Minutes 02.09.19
  - 9.0c – Specialist Surgery Governance SAI Minutes 07.10.19

- 9.0d – Specialist Surgery Governance SAI Minutes 04.11.19
- 9.0e – Specialist Surgery Governance HCAI Minutes 08.04.19
- 9.0f – Specialist Surgery Governance HCAI Minutes 13.05.19
- 9.0g – Specialist Surgery Governance HCAI Minutes 08.07.19
- 9.0h – Specialist Surgery Governance HCAI Minutes 14.10.19
- 9.0i – Specialist Surgery Governance HCAI Minutes 18.11.19
- 9.0j – Specialist Surgery Governance HCAI Minutes 13.01.20

- Divisional Safety and Quality Meeting – Monthly
  - 10.a – Safety and Excellence Meeting Minutes Apr 19
  - 10.b – Safety and Excellence Meeting Minutes May 19
  - 10.c – Safety and Excellence Meeting Minutes June 19
  - 10.d – Safety and Excellence Meeting Minutes Aug 19
  - 10.e – Safety and Excellence Meeting Minutes Sept 19
  - 10.f – Safety and Excellence Meeting Minutes Nov 19
  - 10.g – Safety and Excellence Meeting Minutes Jan 19
- Directorate Senior Management Meeting – Monthly
  - 11.0a – S&SS SMT Minutes 03.04.19
  - 11.0b – S&SS SMT Minutes 08.05.19
  - 11.0c – S&SS SMT Minutes 05.06.19
  - 11.0d – S&SS SMT Minutes 03.07.19
  - 11.0e – S&SS SMT Minutes 04.09.19
  - 11.0f – S&SS SMT Minutes 02.10.19
  - 11.0g – S&SS SMT Minutes 06.11.19
- Incidents
  - 12.0a - BHSCT Risk Matrix - April 2013 (updated June 2016)
  - 12.0b – Cardiac and Thoracic Incidents 01.04.19 - 20.02.20
- Patients Complaints
  - 13.0a - Cardiac and Thoracic Surgery Formal Complaints 01.04.19-20.02.20
- Result of staff survey for the Cardiothoracic surgery service and anaesthetics
  - 14.0a - Surgery and Specialist Services Directorate Staff Survery 2019
- Friends and family test for the Cardiothoracic Surgery Service
  - 15.0a – Ward 5A Patient Experience Report 01.04.19
  - 15.0b – Ward 5A Patient Experience Report 16.04.19
  - 15.0c – Ward 5A Patient Experience Report 22.08.19
  - 15.0d – Ward 5A Patient Experience Report 06.09.19
  - 15.0e – Ward 5A Patient Experience Report 17.09.19
  - 15.0f – Ward 5A Patient Experience Report 03.10.19
  - 15.0g – Ward 5A Patient Experience Report 17.10.19
  - 15.0h – Ward 5A Patient Experience Report 15.11.19
  - 15.0i – Ward 5A Patient Experience Report 28.11.19
  - 15.0j – Ward 5A Patient Experience Report 12.12.19
  - 15.0k – Ward 5A Patient Experience Report 09.01.20
  - 15.0l – Ward 5A Patient Experience Report 23.01.20
  - 15.0m – Ward 5A Patient Experience Report 20.02.20
  - 15.0n – CSICU Patient Experience Report 02.04.19
  - 15.0o – CSICU Patient Experience Report 10.06.19
  - 15.0p – CSICU Patient Experience Report 05.07.19
  - 15.0q – CSICU Patient Experience Report 30.08.19
  - 15.0r – CSICU Patient Experience Report 04.10.19
  - 15.0s – CSICU Patient Experience Report 18.10.19
  - 15.0t – CSICU Patient Experience Report 31.10.19 and 14.11.19
  - 15.0u – CSICU Patient Experience Report 29.11.19
  - 15.0v – CSICU Patient Experience Report 13.12.19
  - 15.0w – CSICU Patient Experience Report 10.01.20
  - 15.0x – CSICU Patient Experience Report 24.10.20

- 17. Waiting List Information
  - 17.0a - Cardiac and Thoracic Waiting List 27.02.20
- 18. Waiting List Cases, including cases at [redacted] and by which consultants
  - 18.0a - Cardiac and Thoracic Waiting List Cases - [redacted] & In House 01.04.19 to 05.03.20
- 19. Minutes of M&M meetings from April 2019
  - 19.0b - Cardiothoracic M&M 11.05.17
  - 19.0c - Cardiothoracic M&M 16.06.17
  - 19.0d - Cardiac M&M 19.09.17
  - 19.0e - Thoracic M&M 19.09.17
  - 19.0f - Cardiac M&M 15.11.17
  - 19.0g - Thoracic M&M 15.11.17
  - 19.0h - Cardiac M&M 14.12.17
  - 19.0i - Thoracic M&M 14.12.17
  - 19.0j - Cardiac M&M 18.01.18
  - 19.0k - Thoracic M&M 18.01.18
  - 19.0l - Cardiac M&M 16.02.18
  - 19.0m - Thoracic M&M 16.02.18
  - 19.0n - Cardiac M&M 16.03.18
  - 19.0n - Cardiac M&M 16.03.18
  - 19.0p - Cardiac M&M 15.05.18
  - 19.0q - Thoracic M&M 15.05.18
  - 19.0r- Cardiac M&M 13.06.18
  - 19.0s - Thoracic M&M 13.06.18
  - 19.0t - Cardiac M&M 18.07.18
  - 19.0u - Thoracic M&M 18.07.18
  - 19.0u - Thoracic M&M 18.07.18
  - 19.0v - Cardiac M&M 16.08.18
  - 19.0w - Cardiac M&M 13.09.18
  - 19.0x - Thoracic M&M 13.09.18
  - 19.0y - Cardiac M&M 19.10.18
  - 19.0z - Thoracic M&M 19.10.18
  - 19.0za - Cardiac M&M 16.11.18
  - 19.0zb - Thoracic M&M 16.11.18
  - 19.0zc - Cardiac M&M 18.12.18
  - 19.0zd - Thoracic M&M 18.12.18
  - 19.0ze - Cardiac M&M 15.01.19
  - 19.0zf - Thoracic M&M 15.01.19
  - 19.0zg - Cardiac M&M 13.02.19
  - 19.0zh - Thoracic M&M 13.02.19
  - 19.0zi - Cardiac M&M 13.03.19
  - 19.0zj - Thoracic M&M 13.03.19
- 21. Freedom to Speak Up Guardian Details
  - 21.0a - Whistleblowing (Your right to raise a concern) Policy
- 22. Freedom to Speak Up Annual Report Covering the department for the last few years
  - 22.0a - Whistleblowing Report 2018-2019
  - 22.0b - Briefing Document - Whistleblowing Report 2018-19
- 23. A governance and reporting structure up to the Trust Board from the department
  - 23.0a - Trust Assurance and Accountability Organisational Overview
  - 23.0b - Division of Surgery Organisational Chart March 2020
- 24. Equality and Diversity Annual Report
  - 24.0a - Equality and Diversity Annual Progress Report 2018.19
  - 24.0b - Regional and Local Equality Action Plan 2018-2023
- Patient Case Notes
  - [redacted]

        - [redacted] 1 of 2
        - [redacted] 2 of 2
    - [redacted]
        - [redacted]
    - [redacted]
        - [redacted] 1 of 8
        - [redacted] 2 of 8
        - [redacted] 3 of 8
        - [redacted] 4 of 8
        - [redacted] 5 of 8
        - [redacted] 6 of 8
        - [redacted] 7 of 8
        - [redacted] 8 of 8
    - [redacted]
        - [redacted] 1 of 3
        - [redacted] 2 of 3
        - [redacted] 3 of 3
    - [redacted]
        - [redacted] 1 of 2
        - [redacted] 2 of 3
    - Supplementary Documentation
        - [redacted] Radiology
        - [redacted] Radiology
        - [redacted] Supplemental
        - [redacted] Radiology
        - [redacted] Supplemental
        - [redacted] Radiology
        - [redacted] Supplemental
        - [redacted] Radiology
        - [redacted] Supplemental
- Other Documents Received
    - RCS visit notes
    - RCS Review 2020
    - Case History[redacted]
    - Chest Wall fixation Audit 2019
    - Consultant training in VATS lobectomy version 4.0
    - Cover Letter to document 2.7 Consultant A
    - Docs for RCS Review
    - Document 2.7 to 2.12 Consultant A
    - Documents 8.1 to M1 Consultant A
    - Documents 31 to 7.1 Consultant A
    - Documents M2 to M14
    - Meeting audio
    - Meeting transcript Consultant C
    - Consultant F - RCS Review Document
    - Consultant B - RCS1
    - RCS 'Investigation' - Consultant C deposition
    - Consultant D – RCS Review
    - VATS lobectomy audit 2019
- Documents received post review visit from staff
    - (A) - (M) Complaints and Concerns Raised
        - (A) Complaint about Consultant C's behaviour from trainee surgeon
        - (B) Complaints from patients, nurses, administrative staff and other trainees about Consultant C's behaviour

- (C) Complaint from thoracic trainees and Charge Nurse, Ward 5a about Consultant B
- (D) Trainees raise about Consultant B's management of 4 cases
- (E) Consultant C challenged on rib fixation by trainee
- (F) Consultant A raises concern about Consultant E
- (G) Consultant D raises concerns about [redacted]
- (H) Consultant E responses to concerns detailed by Medical Director's letter
- (J) (K) Consultant E responses to concerns detailed by Assistant Medical Director's letters
- (L) Consultant E concerns about Consultant A
- (M) Concerns about Consultant F
- Attachments
    - Attachment 1a
    - Attachment 1b
    - Attachment 1c
    - Attachment 1d
    - Attachment 1e
    - Attachment 1f
    - Attachment 1g
    - Attachment 1h
    - Attachment 1i
    - Attachment 1j
    - Attachment 1k
    - Attachment 1l
    - Attachment 1m
    - Attachment 1n
    - Attachment 1o
    - Attachment 1p
    - Attachment 1q
    - Attachment 1r
    - Attachment 1s
    - Attachment 1t
    - Attachment 1u
    - Attachment 2a
    - Attachment 2b
    - Attachment 3a
    - Attachment 4a
    - Attachment 4b
    - Attachment 5a
    - Attachment 5b
    - Attachment 5c
    - Attachment 5d
    - Attachment 5e
    - Attachment 5f
    - Attachment 5g
    - Attachment 5h
    - Attachment 5i
    - Attachment 5j
    - Attachment 5k
    - Attachment 7a
    - Attachment 7b

Email Correspondence

- RE; Cardiac Service
- RE; Cardiac Theatres – ongoing leak
- RE; CSICU Survey
- RE; KCL
- RE: Pre-Audit Management Meeting
- RE; RCS Review of the CR Surgery Service at the Royal Victoria Hospital
- RE; Royal College Visit

- [redacted] achievements in service improvement as Clinical Director
- Cardiac Audit 16.01.2020
- Cardiac Surgery Improvement Group 2
- Comments from Consultant F
- Letter to Chief Executive
- Patient Experience Report 06.03.2020
- Patient Experience Report 06.03.2020

# Appendix E – Royal College Review Team

[redacted] The Royal College of Surgeons of England

[redacted]

[redacted] Society for Cardiothoracic Surgery

[redacted]

[redacted]

[redacted] RCS Lay Reviewer

[redacted]