St George's University Hospitals NHS Foundation Trust

St George's Hospital (Tooting)

Quality Report

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Date of inspection visit: 23 August, 13, 14 September 2018
Date of publication: 18/12/2018

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

St George's University Hospitals NHS Foundation Trust is a combined acute and community health provider. The trust provides secondary and tertiary acute hospital services and community services to the local population. The trust employs over 8,000 WTE staff and serves a population of 1.3 million across South West London.

This is a report on a focused inspection we undertook of the cardiac surgery unit on 23 August, 13 and 14 September 2018. The purpose of this inspection was to follow up on concerns from the Bewick Report that the cardiac surgery unit was a mortality rate alert outlier, on other concerns raised in the Bewick Report published in July 2018, and on concerns raised to CQC.

The concerns focused on patient outcomes and mortality rates, culture, governance and leadership.

We found the cardiac surgery unit was going through a significant transition. Local governance and leadership were weak and were being revised to help improve the service. The culture was poor. Consultant surgeons mistrusted each other, as well as cardiologists, anaesthetists and senior leaders. Morale amongst several consultant surgeons was low and they told us they were under pressure and scrutiny, both internally and externally. There was a reduction in the number of patients accessing the service, as high-risk patients were diverted to other local hospitals and referrals were reduced. Monitoring and oversight by key stakeholders, meant that several measures had been put in place to assist and improve the service.

Our key findings were as follows:

- There was a lack of cohesion and poor working relationships between surgeons, although no direct evidence that this fed through to poor patient outcomes.
- There was not a culture of learning from incidents, mortality and morbidity amongst consultants.
- The quality of mortality and morbidity meetings were poor.
- There were multiple patient record systems, which meant notes were not centrally recorded and there was a risk of information not being accessible or not being handed over adequately.
- Morale amongst several consultant surgeons was low and they told us they were under pressure and scrutiny, both internally and externally.
- There was a lack of ongoing and regular oversight of some aspects of the cardiac services.
- There was a lack of understanding and insight of the performance within the team and the importance and role of national audits.
- Not all staff understood the duty of candour, when it was clearly indicated.

However:

- Bed occupancy rates were being reduced, due to a reduction in referrals and high-risk cases being diverted to other local NHS trusts.
- Comprehensive risk assessments of patients were carried out.
- There was a hospital-wide standardised approach to the detection of deteriorating patients using the National Early Warning System (NEWS) scoring system and staff knew what action to take when the score went above four.
- There were no immediate concerns with regards to patient safety and patients were well-prepared for surgery.
- Latest available data showed the mortality rate for the unit had reduced to 2.7%.

Summary of findings

- Consent to care and treatment was sought in line with legislation and guidance.
- There was ongoing external oversight and monitoring of the cardiac surgery unit by key stakeholders.
- Multidisciplinary (MDT) team meetings, took place daily and involved neighbouring NHS Trusts.
- An independent scrutiny panel for cardiac surgery, set up by NHS Improvement, was appointed to advise, challenge and support the trust.

Importantly, the trust must:

- Review and improve governance systems and processes for the unit.
- Review the quality of mortality and morbidity meetings and include evidence of learning and how this is shared.
- Improve learning from incidents, mortality and morbidity amongst consultants.
- Resolve issues relating to leadership structure and cohesion to support the service to change and improve.
- Address cultural issues within the service to improve multi-disciplinary working and effective governance systems.

In addition, the trust should:

- Review the multiple patient record systems in use, because there was a risk of information not being accessible or not being handed over adequately.
- Ensure all medical staff understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses and to report them internally and externally, where appropriate.
- Ensure all staff understand and apply the Duty of candour procedure, when it is clearly indicated.
- Support staff working in the unit, to improve morale and well-being.

Professor Ted Baker
Chief Inspector of Hospitals

St George's Hospital (Tooting)

Detailed findings

Services we looked at
Cardiac Surgery

Detailed findings

Contents

Background to St George's Hospital (Tooting)

St George's Hospital is located in Tooting, London and managed by St George's University Hospitals NHS Foundation Trust. The hospital serves a population of around 1.3 million people in South West London, with services commissioned by Wandsworth, Merton and Lambeth Clinical Commissioning Groups.

Our inspection team

Our inspection team included;

One CQC inspection manager, a CQC inspector, a CQC national professional advisor (surgery) and a specialist advisor (cardiac surgery).

The inspection was overseen by Helen Rawlings – Head of Hospital Inspection.

How we carried out this inspection

This inspection was triggered by concerns that the cardiac surgery unit was a mortality rate alert outlier, on concerns raised in an external report published in July 2018, and on concerns raised to CQC.

Before our inspection, we reviewed a range of information we held, including the external report, data from the trust, and the trust's action plan and performance data.

We observed how patients were being cared for, spoke with patients and reviewed their personal treatment records. We spoke with 13 members of staff including doctors, nurses, managers and directors.

We observed the environment in which care was being delivered; and reviewed policies and other documents.

Facts and data about St George's Hospital (Tooting)

St George's Hospital offers a range of local services, including: an emergency department, medicine, surgery, critical care, maternity, paediatric services and outpatient clinics. The hospital is also a major trauma centre and provides specialist services in neurology, cardiac care, renal transplantation, cancer care and stroke.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The cardiac surgery unit is located at St George's Hospital and serves the south west of London and surrounding areas. It also receives nationwide referrals as a tertiary unit. As well as routine adult cardiac surgery, the cardiac surgery offers sub-speciality (cardiac) expertise in:

- Mitral valve repair
- Aorto-vascular surgery
- Marfan's disease affecting the vasculature
- High risk and complex patients with comorbidity
- Hypertrophic Obstructive Cardiomyopathy

Cardiac surgery is part of the medicine and cardiovascular division of the trust. However, a patient receiving cardiac surgery will come under three different divisions of the trust, as they progress from pre-operative to post-operative care. There are eight consultant surgeons serving the unit and eight consultant intensivists share the rota for cardiac patients.

There are four theatres available for cardiac surgery. Two are utilised five days a week purely for cardiac surgery, one for thoracic surgery and the other for other surgical activity, but all can be used for cardiac surgery purposes when required.

The anaesthetic department provides 16 anaesthetists with cardiac theatre competency

and all do at least one clinical session per week. In the medical profession, the working week has been historically divided up into sessions, each lasting half a day. Cardiothoracic Intensive Care Unit (CTITU) is a mixed unit for cardiothoracic and non-cardiothoracic patients.

However, there are dedicated CTICU beds with up to 13 available and an additional six rapid throughput beds for lower risk patients. Inpatient beds are available on Benjamin Weir Ward, which has 32 beds.

Facts and data about the trust

St George's University Hospitals NHS Foundation NHS Trust has two hospital locations. St George's Hospital in Tooting and Queen Mary's Hospitals in Roehampton. Both hospitals are based in the London Borough of Wandsworth and serve a population of 1.3 million people.

St George's Hospital offers a range of local services, including: an emergency department, medicine, surgery, critical care, maternity, paediatric services and outpatient clinics. The hospital is also a major trauma centre and provides specialist services in neurology, cardiac care, renal transplantation, cancer care and stroke.

Queen Mary's Hospital has two adult community rehabilitation wards, one for people with limb amputations and the other for older people. There are also outpatient clinics at Queen Mary's Hospital.

The trust also provides limited community health services for people living in Wandsworth.

Surgery

Summary of findings

Our key findings were as follows:

- There was a lack of cohesion and poor working relationships between surgeons, although no direct evidence that this fed through to poor patient outcomes.
- There was not a culture of learning from incidents, mortality and morbidity amongst consultants.
- The quality of mortality and morbidity meetings were poor.
- There were multiple patient record systems, which meant notes were not centrally recorded and there was a risk of information not being accessible or not being handed over adequately.
- Morale amongst several consultant surgeons was low and they told us they were under pressure and scrutiny, both internally and externally.
- There was a lack of ongoing and regular oversight of some aspects of the cardiac services.
- There was a lack of understanding and insight of the performance within the team and the importance and role of national audits.
- Not all staff understood the duty of candour, when it was clearly indicated.

However:

- Bed occupancy rates were being reduced, due to a reduction in referrals and high-risk cases being diverted to other local NHS trusts,
- Comprehensive risk assessments of patients were carried out.
- There was a hospital-wide standardised approach to the detection of deteriorating patients using the National Early Warning System (NEWS) scoring system and staff knew what action to take when the score went above four.
- There were no immediate concerns with regards to patient safety and patients were well-prepared for surgery.
- Latest available data showed the mortality rate for the unit had reduced to 2.7%.
- Consent to care and treatment was sought in line with legislation and guidance.
- There was ongoing external oversight and monitoring of the cardiac surgery unit by key stakeholders.
- Multidisciplinary (MDT) team meetings, took place daily and involved neighbouring NHS Trusts.
- An independent scrutiny panel for cardiac surgery, set up by NHS Improvement, was appointed to advise, challenge and support the trust.

Surgery

Are surgery services safe?

Medical staffing

- Staffing levels did not consistently meet the planned levels of staffing for consultants, however, action was being taken to increase staffing at the unit. The cardiac surgery unit had an establishment for six consultant posts. On the first date of the inspection on 23 August 2018, although there were no vacancies in the team, two consultants were not available for work at that time. By the last date of the inspection on 14 September 2018, the two consultants were available for work and soon after, two additional locums were recruited as recommended by the Bewick Report and started in post**.** Ward staff described inconsistent consultant cover at the weekend. While staff could access an on-call consultant, they described variable attendance at ward rounds.
- Previous arrangements for on-call consultant cover revolved around a firm structure. However, around the time of the inspection, the service moved to a consultant of the week model, which is recommended best practice.
- Prior to the removal of medical trainees, the on-call rota at foundation year 2 (FY2) level (junior doctors in their second year of clinical practice) was compliant, but was not at specialist registrar (SpR) level (junior doctors working at a specialist level).
- Following the inspection, the trust told us SpRs undertook 24-hour shifts as part of a non-resident on-call system. However, they were not required to be on-site for 24-hours, whilst on-call. Junior doctor staffing establishment rates (the number of staff employed against the total number required for the department) for SpRs were 81% for April 2018 and 91% for May 2018. For senior house officer (SHO) doctors these rates were 83% for April 2018 and 80% for May 2018. Rates were being monitored monthly and recorded on a new cardiac surgery services dashboard from April 2018 onwards.

Nurse Staffing

- Nurse staffing vacancy levels on the Benjamin Weir Ward were between 33% and 35% for the months April to July 2018. This was against a target of 15%. On the first day of the inspection, the fill rates (actual nurse staffing levels on the ward) was 100%. Nurse staffing establishment rates (the number of staff employed against the full number required for the department) in Theatres were at 96.6% in April and May 2018. Rates were being monitored monthly and recorded on a new cardiac surgery services dashboard from April 2018 onwards.

Records

- We looked at five patient records. The cardiac surgery unit had several information technology (IT) systems in use, resulting in staff having to access multiple systems to review one patient's care.
- Ward staff used one system for documenting patients' admission, treatment and discharge. There was a different system for scanned documents, another for diagnostic tests and another for documenting admissions to Cardiothoracic Intensive Care Unit (CTITU). In addition, CTITU continued using paper observation charts, which were then stored on the ward.
- We saw some evidence that handover of care took place in patient's notes, however, the multiple record systems meant notes were not centrally recorded and there was a risk of information not being accessible or handed over adequately.

Assessing and responding to risk

- Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance. We carried out pathway tracking on five patient records during the inspection. Electronic records reviewed included risk assessments, care plans and progress notes. We found comprehensive risk assessments were carried out in all records. Staff completed a range of assessments including vital signs, ventilation, repositioning and pressure ulcers, pain, nutritional screening and blood pressure. Surgical patients had generic care plans based on risk assessments and progress notes reflected the care and treatment delivered.
- Staff identified and responded appropriately to changing risks to patients, including their deteriorating health and well-being. There was a hospital-wide standardised approach to the detection of deteriorating patients using the National Early Warning System (NEWS) scoring system and staff knew what action to take when the score went above four and required escalation. Staff knew the escalation process for the

deteriorating patient. Records showed staff on the ward and CTITU, worked closely with each other with regards to deteriorating patients and implementation of the escalation process.

- NEWS scoring was initially completed electronically for each patient on admission and staff response to patient's deteriorating condition was appropriate. Patient observations were done and recorded electronically; and NEWS scores were calculated automatically.
- NEWS scoring audits demonstrated compliance levels of 100% for April, May and July 2018 and 90% for June 2018. This was against a target of 90%.
- Five nurses told us they felt the service was currently safe and they could seek support from senior staff when patient's conditions deteriorated.
- We found some consultants did not feel safe with the pre-assessment system whereby patients in the pre-admission clinic could be assessed by one surgeon, but operated on by another. They told us this was because patients were pooled after the pre-admission clinic and then allocated across the team so they may be operated on by a different surgeon compared to the surgeon who had pre-assessed them. However, pooling eases the issue of vacant operating slots not being uniform across the surgical team. Pooling was also referred to in the cardiac surgery action plan as a positive step to ensure clinical and operational review of the current waiting list and appropriate allocation of patients.

Incidents

- Ward staff we spoke with were clear about their responsibilities to record and report incidents and gave examples where learning from incidents had been shared. When incidents occurred, they were reported via and electronic incident system and the nurse-in-charge informed. Policy and practice were changed as a result of learning from incidents. We were told of a change of policy which occurred following a serious incident. Following an investigation, a new policy on temporary external pacemakers was implemented. One nurse told us the ward manager or matron gave staff feedback on the outcome of the investigation.
- Whilst we found evidence that the Duty of candour was applied appropriately, we were told by staff, one consultant had to be encouraged to carry out the procedure, following an incident where it was required. In that instance, the consultant failed to fully explain the situation in a way that the family could understand. This interaction resulted in increased concern and lack of understanding by the family which then had to be dealt with by ITU staff. We reviewed this case and it was documented that the Duty of candour was applied. The trust did not raise the initial failure to explain the situation to the family as an incident.
- The consultant involved, also told us they were unclear whether an incident form had been completed for the relevant incident. As a result, we had concerns whether this individual understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses and to report them internally and externally, where appropriate.
- The cardiac surgery unit regularly collected and submitted information on safety performance to the Safety Thermometer and National Institute for Cardiac Outcomes Research (NICOR). The ward monitored and displayed safety performance over time.
- There were arrangements for reviewing and investigating safety incidents when things went wrong. Serious incidents were investigated using the Serious Incident Framework 2015. We reviewed five serious incidents in 2018, that resulted in investigations using the framework. However, three consultants told us, they did not feel the learning from lessons was shared, to make sure action was taken to prevent recurrence.
- Joint cardiology and cardiac surgery mortality and morbidity meetings was due to begin taking place every three months and there was a monthly 'surgeons-only' meeting. The governance lead attended the surgical mortality and morbidity meetings. They told us the quality of the meetings were poor and differed from cardiology mortality and morbidity meetings. Staff told us surgical mortality and morbidity meetings did not tend to focus on the cases with most learning or have open discussions as in cardiology.
- We found mortality and morbidity meetings were not robust and were not held with a culture of learning. We reviewed the notes from three meetings in 2018 and we found discussions were not fully documented. Staff told us the discussions which took place were more often

used as a way of shifting blame onto others, rather than trying to learn from incidents. Three consultants told us one of their colleagues also interacted poorly during mortality and morbidity meetings.

- We reviewed incidents and there were conflicting views about how emergency medical cover was provided in theatres. In one example, the trust told us emergency medical cover was managed well, while a member of staff told us it was not. However, the operation was performed successfully and there was no harm to the patient.

Safety Thermometer

- Clinical risk assessments were completed for patients including venous thromboembolism (VTE) on admission and at 48 hours post admission. The service monitored compliance with VTE risk assessments. Compliance rates were not always being met but were near to the requirement and were 96.8% for April 2018, 97% for May 2018, 100% for June and July 2018. This was against a target of 100% meaning that compliance was achieved for 2 out of 4 months.
- The service monitored the number of pressure ulcers and falls that occurred. For April to July 2018, no grade 3 or grade 4 pressure ulcers were reported. For the same period, a total of 11 slips, trips and falls were reported for Benjamin Weir ward. During April and May 2018, the number of slips, trips and falls were above the trust target of two per month, with three occurring in April and six in May. For June, this had reduced to two and for July, there were none.
- Soon after the inspection, from the 20 September 2018, daily updates on numbers of grade 3 and 4 pressure ulcers were being reported, so an enhanced view of these could be seen. For the week 20 – 26 September, there were no incidences of grade 3 or 4 pressure ulcers.

Are surgery services effective?

Patient outcomes

- The intended outcomes for patients were not always achieved. Information showed that outcomes for people in this service were worse than the national average.
- The Bewick Report identified that the cardiac surgery unit received an initial alert from the National Institute for Cardiac Outcomes Research (NICOR) in 2017. An alert is issued by NICOR when the rate of mortality is 2 standard deviations higher (worse) than the average mortality rate for the other 31 cardiac surgery units in the UK. This alert identified that there was a worse (higher) mortality rate for patients receiving care at the trust when compared to the other 31 cardiac surgery units in the UK. After this first NICOR alert, the trust's medical lead for mortality monitoring undertook an internal review and established a Cardiac Surgery Task Force.
- A second alert was received by the unit from NICOR in April 2018. This referred to the mortality rate for 2014-2017. After this second NICOR alert, the trust commissioned the Bewick review. The overall mortality rate for all patients receiving cardiac surgery in the UK 2013 - 16 (NICOR data) was 2.0%. The overall mortality rate for patients operated on at St George's Hospital for calendar years 2014 - 17 inclusive was 3.7%. NICOR did not disclose the alert data to CQC at the time it was identified, as this is their policy. The detail of the data only became available after the publication of the Bewick Report in July 2018.The trust had a task group that reviewed mortality rates for patients treated at St George's Hospitals for cardiac surgery and there was an agreed action plan to address these.
- Latest data reviewed by the trust's task group, showed the mortality rate for the unit had reduced to 2.7% for the period January to August 2018, from 3.6% for 2017.
- Bed occupancy levels was manageable as there was a good consultant to patient ratio of 1 consultant to 2.25 patients (1:2.25). Since the inspection, a series of measures which included a reduction in referrals to the unit due to complex cases being diverted to other local NHS trusts, meant the daily average number of patients had reduced from 29 in January 2018 to 18 in July 2018. This was a 32% reduction since the start of the year.

Competent staff

- On Benjamin Weir Ward, the service had systems in place to ensure staff had the skills and knowledge to meet the needs of patients. The ward had a dedicated competency booklet to help train newly qualified nurses in cardiothoracic care and had also recently appointed a practice educator to ensure staff competency.
- Arrangements for supporting and managing locum staff to deliver effective care and treatment were not always

adequate and staff raised some concerns regarding the processes and procedures for recruiting, inducting and supervising them. However, we noted two locums were recently appointed. The locums were known to the department and the trust told us they had some degree of assurance that they could be supervised to deliver safe cardiac surgery. We reviewed information from the trust and NHS Improvement which demonstrated an improved recruitment and induction process for locum staff and monitoring of practice and support while they worked on the unit.

- The trust informed us on 6 September 2018, that the Royal College of Surgeons was supporting them, with regards to some of the issues on the unit.

Consent

- Consent to care and treatment was sought in line with legislation and guidance.
- Records demonstrated that staff ensured informed consent was given by speaking to pre-operative patients about their understanding of their surgery, as well as informing them of the risks and potential complications.
- Consent to care and treatment was evident in all five patient records we reviewed. Operation notes were accurate and reflected the surgery which were performed.

Multidisciplinary working

- Multidisciplinary (MDT) team meetings, took place daily instead of weekly, as it was previously and involved neighbouring NHS Trusts. This helped to improve the governance of the unit. Daily MDTs also helped the team to evaluate the waiting list and improve the visibility of patients being admitted. MDTs were attended by cardiologists and all cardiac surgeons. Cases were allocated to surgeons, with a surgery slot and full discussions held with surgeons. The elective list was reviewed by a consultant cardiologist, to determine which cases should be redirected to other local hospitals.

Are surgery services caring?

This key question was not inspected.

Are surgery services responsive?

This key question was not inspected.

Are surgery services well-led?

Culture

- The culture within the cardiac surgical service did not always encourage openness and honesty and we found that staff did not work together to ensure delivery of high quality, safe and effective services that put patients at the centre. Behaviours were not in line with the values of the trust.
- Consultants did not work collaboratively, share responsibility or resolve conflict in a constructive and timely manner. There were high levels of mistrust amongst clinical colleagues which contributed to the poor culture within the service.
- Consultant cardiac surgeons were described as having 'strong' personalities who were unable to work together effectively, with one consultant describing the culture as one of 'tribalism'.
- Some surgical staff described poor working relationships and a culture of bullying and harassment between surgical, anaesthetic and intensivist teams which impacted negatively on the effective running of the unit.
- There was a lack of effective multi-disciplinary working amongst consultants across specialities and we heard of many examples where cardiac surgeons did not work well with other consultant colleagues in different specialities.
- Some staff including consultants, told us that they did not feel supported, respected or valued and there was a hierarchical culture in existence within the service.
- Not all staff felt confident at raising concerns, some staff told us that they felt intimidated by some surgeons particularly during operations. One member of staff told us they felt that whilst the trust had a Freedom to Speak Up Guardian and a policy for encouraging staff to raise concerns, it was ineffective. They told us when other staff had raised concerns to the senior leadership team, there had been no action taken.

- One consultant was described as demanding and staff were reluctant to speak up when they had concerns about their practice or behaviour.
- Staff told us of poor working relationships and difficulties working with some cardiac surgical consultants, poor levels of communication within the team and varying levels of safety dependent upon individual practices.
- Staff told us the cardiac surgical team had not worked effectively for several years and the environment was one of hostility between the surgeons. They described an unpleasant working environment with victimisation of one surgical colleague.
- Access to the CTITU was described by some staff as being difficult due to the unit being 'closed'. One consultant raised concerns that surgical opinions were not sought by intensive care colleagues. However, working relationships between the anaesthetic teams was described as good and that they worked as a team.
- Morale amongst several consultant surgeons was described as low. This was partly attributed to the poor culture and to the high levels scrutiny the service was subjected to both internally and externally. The trust planned to commission an external agency to work with the teams to provide psychological support to staff and ensure their well-being.
- The trust commissioned an external cultural review which was taking place at the time of our inspection to understand these issues further and consider steps to improve the culture.
- Nursing teams were more positive about the culture and working environment on the cardiac surgical wards and described effective working relationships between themselves and the Surgeons.
- In December 2017, the Cardiac Surgical team took part in a team mediation event, held over two days. This was reported as having a positive impact initially and was successful for a time however the improvement was not sustained and after a few months staff reported a return to poor behaviours and a resurfacing of previous issues.

Leadership

- We were not assured there was credible and effective leadership or managerial oversight at service, divisional or trust level, that was able to identify and address the issues that existed within the cardiac surgical service.
- There was a lack of effective clinical leadership within the service, following the mediation in December 2017, it was agreed there would be a clinical lead appointed with the support of the consultants within the service. However, this role had very little impact in terms of improvements needing to be made, as staff reported a return to previous poor behaviours shortly after the event.
- Whilst there had been external reviews commissioned in 2010 and again in 2018 into the functioning of the cardiac surgical department with associated action plans, there was very limited evidence of any improvement over a prolonged period.
- Communication was not always effective. During the inspection it was apparent that not all members of the team were aware why patients who were deemed high risk for surgery had been diverted to other trusts. We were told that not all consultant cardiac surgeons were aware of a letter sent to patients informing them of the transfer of their care.
- Surgeons were concerned that a letter raising concerns regarding the safety of the service had not been shared with them by senior managers, despite them asking for it to be shared.
- Since the publication of the external review of the service in July 2018, the senior management team had acted in collaboration with external partners to begin to address the ongoing concerns of safety, culture and leadership within the service.

Governance

- There were weak governance systems and processes operating within the service which were further undermined by the poor culture that existed amongst the cardiac surgical team.
- It is acknowledged that the senior leadership team had been in post for 18 months and the issues within the

cardiac surgical team had existed for more than eight years. However, the impact of intervention to address cultural issues had lacked pace and not improved the situation.

- There was a lack of regular oversight of safety and quality data and we were not assured that the systems and processes that were in place allowed for timely identification of issues or concerns to ensure delivery of safe and high-quality services.
- Whilst there were regular meetings staff told us these were ineffective and that there was minimal dialogue between surgeons and other staff.
- We found that morbidity and mortality meetings were of poor quality. Joint morbidity and mortality meetings between cardiology and cardiac surgery were held three monthly and there was a monthly meeting for surgeons only.
- Staff told us that the quality of the surgeon only meetings were poor, lacked focus and did not allow for any learning.
- We reviewed three sets of minutes from morbidity and mortality meetings, we did not see evidence of learning and there were concerned that there was a focus on blame rather than learning.
- Serious incidents were investigated and we saw action plans were in place. However, we were not assured that learning was always shared appropriately due to the poor culture within the service.
- During the inspection, a cardiology consultant had been appointed as governance lead for the service.
- Changes had been made to clinical ward rounds to ensure they took place daily and Surgeons were joined by consultant cardiologists however we were told that further improvements needed to be made and that a number of consultant surgeons were dissatisfied with the level of input from the cardiologists informing us they felt they were being governed by cardiology.
- We saw that duty of candour was applied appropriately, however, we were informed of one case where an individual had to be encouraged to inform a patient of an incident and failed to fully explain the situation.
- Since the inspection external oversight and monitoring of the cardiac surgical service has been established. Multi-disciplinary team meetings now take place daily with input from clinical teams from neighbouring cardio-thoracic services to ensure that patients are directed to the most appropriate service.
- A steering group had been established to have oversight of the actions the trust had begun to implement. An Independent Scrutiny Panel with both clinical and managerial expertise had been established in October 2018. The purpose of the panel was to advise, challenge and support the trust's actions in addressing the issues with its provision of cardiac surgical services, with a view to ensuring the quality and safety of those services. A review of governance processes will take place and further changes and improvements made to ensure services are safe and of high quality.

Managing risk, issues and performance

- There was a lack of understanding, insight and managerial oversight of performance within the service and the importance of national audit outcomes. The governance lead felt the governance of data was satisfactory and the unit had been unfairly criticised, in relation to NICOR data.
- There was a risk management system in place and the service had a risk register which we reviewed. We were not assured that all risks were identified, documented and addressed. Risks were reviewed on a regular basis, however, there was a gap in the risk register and mitigating actions around governance. This had been addressed at the time of the second day of our visit.
- There was a draft performance dashboard in place at the time of our initial inspection. This was populated with some performance data relating to risk, issues and performance. Ongoing review of this dashboard during further inspection activity, demonstrated this dashboard had improved to include detailed daily information on risk, issues and performance to allow the unit to be evaluated on an ongoing basis.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Review and improve governance systems and processes for the unit.
- Review the quality of mortality and morbidity meetings and include evidence of learning and how this is shared.
- Improve learning from incidents, mortality and morbidity amongst consultants.
- Resolve issues relating to leadership structure and cohesion to support the service to change and improve.
- Address cultural issues within the service, to improve multi-disciplinary working and effective governance systems.

Action the hospital SHOULD take to improve

- Review the multiple patient record systems in use, because there was a risk of information not being accessible or not being handed over adequately.
- Ensure all medical staff understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses and to report them internally and externally, where appropriate.
- Ensure all staff understand and apply the Duty of candour procedure, when it is clearly indicated.
- Support staff working in the unit, to improve morale and well-being.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established and operated effectively because: 1. There was a poor governance structure, which meant concerns and issues were not routinely assessed, monitored and acted upon to improve the quality of services. 2. The quality of mortality and morbidity meetings were poor and it was not clear how learning was identified and shared. 3. There was not a culture of learning from incidents, mortality and morbidity amongst consultants. 4. The leadership structure was not cohesive and did not support the service to change and improve. 5. Cultural issues within the service limited effective multi-disciplinary working and effective governance systems. Regulation 17