The Newcastle upon Tyne Hospitals NHS Foundation Trust

Freeman Hospital

Inspection report

Freeman Road
High Heaton
Newcastle Upon Tyne
NE7 7DN
Tel: 01912336161
www.newcastle-hospitals.org.uk

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Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Freeman Hospital

Inspected but not rated

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection. This report describes our judgement of the quality of care provided by this service. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, staff, the public and other organisations. This inspection was very focused and not rated. Any MUST do's, SHOULD do's and regulatory breaches are referenced in the core service report from inspection dated June 2023.

Surgery

Inspected but not rated

We carried out this unannounced focused inspection on 28 September 2023 of the Cardiothoracic surgery department (part of the surgical core services) because since our inspection of surgery in June and July 2023, we received information giving us concerns about the safety and quality of the services.

This inspection was very focussed following up on information of concern, and as such is an inspected and not rated inspection.

The Cardiothoracic surgery department is delivered out of Freeman hospital and is a service that forms part of the surgery core service. The service provides local, regional, and national services for those requiring cardiothoracic services which includes heart and lung surgery and transplantation services for adults and children.

During our inspection in June and July 2023, we received whistleblowing concerns regarding the culture specifically about bullying and harassment within the cardiothoracic service. We continued to receive whistleblowing concerns after our onsite inspections during August and September 2023 with specific examples of patient safety concerns. These included concerns relating to: -

• Specific types of surgery and the training, skills, and competence of doctors, including professional practice concerns.

• concerns about the management of patients due to the behaviours of some staff,

• completion of patient records and the accuracy of them

• management and prioritisation of emergency and elective patients leading to delays that were impacting on patients' safety.

• the effectiveness of multi-disciplinary team meetings and clinical decision making

• a backlog of 'unverified' letters following clinic appointments, patient treatments and operations and inpatient stays.

• Delays in lung cancer pathways and potential impact on patients

• High rates of non-surgical procedures for patients who require revascularisation (a procedure to restore blood flow) compared to national averages.

We did not rate the cardiothoracic service at this inspection. The surgical core service rating of requires improvement remains.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/whatwe-do/how-we-do-our-job/what-we-do-inspection.

Surgery

Is the service safe?

Inspected but not rated

Mandatory training

See surgery section in core services report from inspection dated June 2023 for full details.

Safeguarding

See surgery section in core services report from inspection dated June 2023 for full details.

Cleanliness, infection control and hygiene

See surgery section in core services report from inspection dated June 2023 for full details.

Environment and equipment

See surgery section in core services report from inspection dated June 2023 for full details.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient however, there was a lack of consistency in managing elective and emergency patients. There were not robust procedures in place and leaders did not address issues quickly to reduce risks to patients.

At an engagement meeting on 07 February 2023 with the trust, CQC sought information and assurances on how the trust managed elective and emergency patients. The trust told us they had implemented a duty ward surgeon each week. The duty ward consultant would take responsibility for the twice daily ward rounds and manage emergency admissions, inhouse unstable patients and provide support into the Emergency Department at the trust's other location Royal Victoria Infirmary (RVI). Rotas had been implemented to identify which consultant covered the ward. In addition, a week on the ward, ward cover document 2022 had been devised. During the factual accuracy period the trust told us that week on the ward only related to cardiac surgeons.

Within this document it stated that consultants "may choose to do no scheduled operating, swapping with colleagues for the following week when they are doing ward duty, or continue with your operating schedule cognisant of the fact that your primary responsibility that week is to the ward/unstable system and plan cases and assistance accordingly." It also stated that "You must be contactable at all times for the ward or unstable co-ordinator for advice during working hours that week." It was identified in the revised action plan September 2013 that a Cardiac surgery standards document was now in place which was an enhancement on the previous document however, when we spoke with the management team from the clinical board, they identified this was a document that still needed to be developed and they were working to the existing process.

When we visited the wards during our inspection, we found that the thoracic consultant who was providing ward cover was operating on elective patients which meant that they were not contactable at all times. When we spoke with staff,

they told us they would try to contact other consultants or had to wait for the surgeon to become available. Staff were equally unclear as to which consultant was covering the cardiac rota. They thought this might have been changed as consultants would change their rota obligations without informing the wider team which could lead to confusion and delays when staff tried to contact them for support.

When we asked the management team about this, they told us there were robust systems in relation to the on-call rota and that more detailed work to allocate specific tasks to certain surgeons was underway. However, they acknowledged that job planning was delayed and there had been confusion as to who was covering what on the day we inspected. This could potentially lead to delays in patients receiving timely care if staff were having to ring around to get doctors to review patients on the ward.

A revised action plan shared by the trust in September 2023, at the Quality review meeting indicated that there was further work being undertaken to look at an enhanced surgeon of the week model where consultants would have no scheduled operating and an enhanced focus on ward duties. This action was currently rated as amber and was due for completion in December 2023.

There was a surgical planning meeting held every week where diary commitments for cardiac, thoracic and catheter labs were discussed. The waiting list administration team, the co-ordinator and theatre co-ordinators attended this meeting, to look at the lists to ensure sufficient time was allocated or if unstable patients needed priority. We were told surgeons did not routinely attend this meeting and individual discussions with doctors would happen following the meeting. We could not see how the department had robust processes in place to management patient priorities with sufficient oversight from leaders or clinical staff in the service.

We looked at the unstable patient list whilst we were on inspection and saw detailed information on the patient's condition including any investigations or actions required. For example, we saw one patient had been accepted for a coronary artery bypass graft and was waiting a date for surgery. It was clearly identified that the surgeon wanted one of the patient's blood counts to be at a certain level before the procedure could be undertaken. We also reviewed information for another patient where they had been admitted into another hospital and was awaiting transfer to the service. It was identified on 15 September 2023 that they were unable to be transferred to ward 25 as there was no telemetry bed available, it was documented on 22 September that there was still no bed available. The other hospital was then contacted on 25 September, and it was identified the patient wasn't having any telemetry monitoring and was subsequently transferred to ward 25 that day. The information also stated there was an MDT discussion on 26 September and the patient was to have a cardiac surgical operation.

The trust used their own transport service NECTAR or North East ambulance service (NEAS) to transport emergency patients from the emergency department at the RVI to the cardiothoracic wards at the Freeman. Between 01 August 2022 and 01 February 2023 there had been 191 transfers undertaken.

See surgery section in core services report from inspection dated June 2023 for full details.

Nurse staffing

Staff told us there were challenges with staffing particularly within theatres which impacted on the full availability of theatre capacity. This included theatre staff. The trust was actively recruiting to any vacancies but in the meantime staffing levels remained a challenge.

Surgery

There was a dedicated high dependency bay with nurse-to-patient ratios in line with national standards of one nurse to two patients. Staff told us this was always maintained and protected from staffing shortages. Staffing on the day of inspection on ward 25 was below the planned but additional staff had been sought to support the ward.

See surgery section in core services report from inspection dated June 2023 for full details.

Medical staffing

In addition to permanent consultant staffing there were additional locum doctors and nurse practitioners to support the wards. We observed ward rounds and found the nurse practitioners led these with support from the locum consultant, they ensured all test results and updates were discussed and there were appropriate interactions with patients about their condition.

See surgery section in core services report from inspection dated June 2023 for full details.

Records

See surgery section in core services report from inspection dated June 2023 for full details.

Medicines

See surgery section in core services report from inspection dated June 2023 for full details.

Incidents

The service did not always manage patient safety incidents well. Staff recognised but did not always report incidents and near misses for fear of retribution. Managers investigated incidents but this was not always timely, and lessons learned were not shared with the whole team and the wider service. When things went wrong, there were delays in staff apologising and giving patients honest information and suitable support.

Staff knew what incidents to report and how to report them, however, this was not always done in a timely way. Prior to this focused inspection a number of staff contacted CQC and told us they were fearful of raising patient safety incidents for fear of the consequences and retribution. More detailed findings are reported within the culture section of the report.

The trust identified a number of cases at a meeting in January 2022 which met the threshold as a serious incident (SI). However, there was a significant delay in reporting them on the Strategic executive information system (StEIS) as serious incidents and this was not done until November 2022. The trust had waited to fully investigate them before reporting them, which was not in line with NHS England's Serious incident framework 2015 which states it should be reported onto STEIS no later than two days after the incident has been identified. This also meant there were delays in meeting duty of candour for the patients and relatives involved.

Following this a thematic analysis had occurred and identified a number of safety recommendations for the service. As part of our trust wide inspection and from feedback given directly to CQC from staff working in the service, we were concerned at the pace of action from the trust in delivering their action plan for this review. Staff we spoke with were not

aware of the action plan with the management team confirming this was the case. This meant staff had not been engaged with to make the service improvements which resulted in the actions not being fully implemented, embedded, or sustained. This also meant the improvements that were needed to address patient safety concerns had not been made.

Within meeting minutes of the trust wide mortality surveillance group in July 2022, we found one case discussed specifically for cardiothoracic surgery. This case had been discussed at the serious incident triage panel as the patient's operation had been cancelled twice due to the lack of an intensive care bed and no theatre capacity. The operation did take place three weeks later and the department highlighted the delays may have contributed to the patient's death. However, a serious incident had not been declared with the rationale documented in the minutes of the meeting as "It was agreed at SI panel this was not an SI as sadly it was not uncommon to have a lack of ITU beds and/or theatre space." It was unclear from the minutes whether a thorough review of this case had occurred to enable identification of opportunities for learning and to reduce the chance of reoccurrence in the future. Known reasons of organisational pressures and challenges do not exempt the reporting of serious incidents, and this is not in line with a positive safety culture that is committed to learning and mitigating risks to the lowest points.

CQC's review of incidents reported onto the national reporting and learning system (NRLS) in 2022-23, identified themes of incidents relating to managements of waiting lists, documentation, transplant services, theatre capacity, clinical concerns, and service delivery. Many of these areas were discussed as part of CQC's engagement with the trust and as part of the quality review meetings in 2022 and during 2023. The Trust has since developed an action plan to improve in these areas and embed learning from incidents across the Clinical Board.

Is the service effective?

Inspected but not rated

Evidence-based care and treatment

See surgery section in core services report from inspection dated June 2023 for full details.

Nutrition and hydration

See surgery section in core services report from inspection dated June 2023 for full details.

Pain relief

See surgery section in core services report from inspection dated June 2023 for full details.

Patient outcomes

See surgery section in core services report from inspection dated June 2023 for full details.

Competent staff

See surgery section in core services report from inspection dated June 2023 for full details.

Surgery

Multidisciplinary working

See surgery section in core services report from inspection dated June 2023 for full details.

Seven-day services

See surgery section in core services report from inspection dated June 2023 for full details.

Health promotion

See surgery section in core services report from inspection dated June 2023 for full details.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

See surgery section in core services report from inspection dated June 2023 for full details.

Is the service caring?

Inspected but not rated

Compassionate care

See surgery section in core services report from inspection dated June 2023 for full details.

Emotional support

See surgery section in core services report from inspection dated June 2023 for full details.

Understanding and involvement of patients and those close to them

See surgery section in core services report from inspection dated June 2023 for full details.

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of local people.

See surgery section in core services report from inspection dated June 2023 for full details.

Meeting people's individual needs

See surgery section in core services report from inspection dated June 2023 for full details.

Surgery

Access and flow

As part of the inspection, we spoke with clinical and non-clinical staff on the management of waiting lists within the cardiothoracic department. There was an inconsistent understanding from staff in the department on how waiting lists were managed; some staff told us consultants managed their own waiting lists with their secretaries, whereas other staff (mainly managers and senior leaders) described that most waiting lists were centralised with weekly oversight on this. Staff who monitored the thoracic waiting lists told us they only monitored patients who were due to have a general anaesthetic and separate administration teams monitored the 18-week referral to treatment times. They described clinical oversight of the waiting lists and prioritisation of those for surgery by the thoracic surgeons. At present they told us the cardiac surgeons had chosen to manage their own waiting lists and there was no central oversight. This correlated with information CQC received from staff working in the service.

At the August 2023 quality review meeting the trust identified that 75% of the waiting lists were to be centralised and managed by the team (which equated to 100% of high-risk waiting lists) by the end of November 2023, the remaining 25% of lower risk waiting lists were due to be centralised by the end 2023/24.

At this meeting, CQC raised concerns about the low percentages (28%) of lung cancer waiting time performance and the potential for harm that could have an impact on prognosis for patients. At the following meeting in September 2023, the trust reported this had improved over the last month, when asked how this had been achieved, they responded by stating this had been achieved by 'pooling' the waiting lists. The trust reported the waiting times had been over 7 weeks and now had reduced to 31 days. Between the August and September meeting the trust had managed to make significant improvements in this short space of time. However, it was unclear if the trust could make significant improvements in a month, why they had not been able to make these rapid improvements before it was highlighted to them as an area of concern.

When we spoke with the cardiothoracic board management team, they confirmed the thoracic waiting lists had been centralised in January 2023, and that the cardiac waiting list was still to be centralised. Whilst actions were due to be complete by the end of November, we remained concerned about whether the trust would be able to achieve these timescales, the pace of actions and the current management and oversight of waiting lists. This was a particular concern, as waiting list management had been identified as themes in incidents and serious incidents over the last 12-18 months and waiting list management had been raised by CQC in trust engagement in February 2023.

See surgery section in core services report from inspection dated June 2023 for full details.

Learning from complaints and concerns

See surgery section in core services report from inspection dated June 2023 for full details.

Is the service well-led?

Inspected but not rated

Leadership

See surgery section in core services report from inspection dated June 2023 for full details.

Surgery

Vision and Strategy

See surgery section in core services report from inspection dated June 2023 for full details.

Culture

Staff did not always feel respected, supported, and valued. The service did not have an open culture where staff could raise concerns without fear.

There is a long-standing history of concerns about the culture within the Cardiothoracic surgery department dating back several years. In 2017-18 concerns were highlighted during the trusts own peer review processes, specifically related to a hierarchical culture and absence of psychological safety within the cardiac surgical team. As part of engagement the trust provided a list detailing executive actions following this report. These concerns continued into 2019 where further issues were raised from the GMC trainee survey and recruitment issues. Information the trust shared stated there had been a collective decision to improve the issues related to team dynamics; psychological safety in the department, the hierarchical culture and improve freedom to speak up processes in the department.

Significant improvements had been identified in the trusts annual review of the department, as evidenced by staff feedback regarding safety culture, teamwork, and behaviours. However, this was not sustained and in December 2020, trainees raised concerns to Health Education North East about training and support opportunities.

Following this, the trust commissioned a Royal College of Surgeons invited review in 2021 which further highlighted significant concerns about the culture in the department. The report highlighted that there had been a breakdown in relationships that had impacted on the service's ability to function as a cohesive and supportive team.

The review concluded that interpersonal and behavioural issues in the unit were perpetuated by a lack of intervention at executive level. The review team noted, there appeared to be a reluctance by some senior staff to take responsibility or effective action to resolve the factionalism. This had contributed to issues continuing within the unit for a prolonged period of time and staff were losing confidence in management to remedy or manage situations appropriately. Despite the report highlighting the concerns about culture, we have found during our inspections that there appears to have been little effective action taken by the trust to address the cultural concerns in the service.

The trust further undertook a thematic analysis in 2022 following a number of serious incidents, this review also highlighted concerns about culture in relation to morbidity and mortality meetings. It found that the majority of staff describing these as "bullying" and "humiliating", whereas others considered the atmosphere to be one of "robust challenge". The review team concluded that this highlighted "a lack of openness to learning and psychological safety within the department."

One of the recommendations specifically highlighted that "The directorate, with support from senior management, to create a psychologically safe climate for individuals to share experiences or concerns and for others to listen without reacting. The investigation considers that that external expert (independent) help will be required to support the required cultural change." The updated action plan shared by the trust at the Quality risk meeting in September 2023, showed the two key actions related to the culture recommendation had still not been completed and had target dates of December 2023 and March 2024. This showed the trust had not moved with pace to address the cultural work in the service and if they remained on target this work, the cultural programme would only commence in March 2024, some 18 months after the recommendation was made. The trust did share they were undertaking their own cultural survey in the service, and this was due to commence in the following few months.

Surgery

We have found that there was a continued lack of decisive action taken by the trust and it had failed to address the culture in the department over a number of years. Whilst actions had been identified, the trust had failed deliver them and the poor culture had continued; making this an uncomfortable environment for some staff to work within and had the potential to impact on the care people received.

CQC have spoken to 69 staff who have shared their experiences with us directly (whistleblowing), and there were 53 specific comments relating to this service.

Some staff members did share positive experiences, although these were often about the wider trust rather than the Cardiothoracic department. Indeed, despite finding the environment in the unit challenging, some staff told us they felt valued by the Trust as a whole. For example, comments included: -

“I believe that the trust wants to provide optimum support for staff at all levels and does its best to achieve this consistently under the very difficult circumstances of recent times (i.e.: relentless patient demand, staff illness levels, changing work-life balance considerations post pandemic, etc, etc).”

Staff were particularly proud of the safe and effective care they provide.

“Having said this, I enjoy working in the Trust. I have a good team of colleagues. We work well together and provide safe and effective care most of the time. The recent addition of new Consultant colleagues and cross-site working for the RVI (Royal Victoria) on call has established a good working relationship between the sites. The recent change in the CD (Clinical Director) and deputy CD role in the cardiothoracic department has been encouraging.”

New leadership structures were also mentioned. Some felt this was positive mentioning the culture had improved with the process.

“I think the overall Trust management culture has improved in recent years.”

During our onsite inspections we observed staff working hard to ensure patients received safe and effective care. However, staff described this was often difficult with tense relationships between some medical staff which made the environment a challenge to work within.

All patients we spoke with described positive interactions with the staff they met, and they had positive experiences of care.

However, many of the comments concerned leadership within the Cardiothoracic department, specifically around bullying and raising concerns, rather than trust senior management although many felt Trust leaders overlooked or ignored issues within the Cardiothoracic department.

Some felt communication from leadership in the Cardiothoracic department was “poor” leaving them unaware of “things going on in the department or wider trust”. They referred to a “talk down culture” leading to a “loss of morale” with colleagues. They also felt rationales behind decisions or lessons learned were not adequately explained to them.

Surgery

Many of the comments staff have shared with us, have concerned bullying, harassment, and abuse in the Cardiothoracic department. Staff told us rumours of bullying in the Cardiothoracic department have circulated around the trust for a number of years. There was a sense throughout what staff have told us that experiencing or witnessing bullying was almost the norm in the department, with different staff groups communicating to other groups in an unprofessional manner. This was not limited to surgeons or consultants, but also affected nurses and other members of staff.

“Often the senior management and surgeons are vile to staff, you do not dare raise any concerns, the medical staff talk to each other terribly and often argue in front of junior staff and patients the management are nothing but bullies.”

“Sadly, our trust has become a place of toxicity and bullying none more so in the cardio thoracic directorate, over the years the surgeons and management staff have ruled the speciality though fear of reputation.”

“Senior management have a long history of bullying, intimidating and punishing staff who speak up over patient safety concerns.”

“The culture of this directorate (or board) is one of negativity. Serious incidents were deliberately covered up and information that should have been shared were not and that would have changed outcomes. Bullying of senior nurses by cardiothoracic management was appalling.”

“I have found this organisation to be toxic, acts in an arrogant manner and staff are too scared to tell the truth for fear of retribution. What saddens me the most is the number of staff who have experienced similar and left the organisation as a result without management wishing to explore the reasons why. The worst thing an employer can do is not listen to its staff and demonstrate a willingness to learn.”

“The culture in the cardiothoracic department is the worst it has ever been infighting, bullying and a complete disregard for governance, managers are vile and often bully staff to get their way and then later backtrack. This is well known throughout the trust executive team, but no one cares. Also, the behaviour of the medical staff is awful to the nursing teams and there’s often arguments and fighting which is witnessed by junior members of the team again this is well renowned in the trust, and nothing is done it is just accepted.”

Particularly in relation to patient safety, staff who have spoken up to CQC directly or commented in our survey often shared that there was “a long history of bullying, intimidating and punishing staff” often those “who speak up over patient safety concerns”. Examples of “shouting, gesturing” and “dominant, pushy behaviour” were often described.

The most concerning comments were descriptions of bullying connected with a very real fear of retribution or reprisal. Where wider trust management was mentioned, it was in relation to turning “a blind eye” and not acting upon allegations of bullying in the department.

Some comments included: -

“It’s been hugely distressing to see patients come to harm, and I feel I’ve paid a high price for raising concerns.”

“I’ve been intimidated and it’s a day-to-day struggle.”

“I’m now not sure I would raise patient safety concerns due to the response in the department.”

Surgery

Some respondents in our survey told us they had already raised concerns anonymously, but this anonymity was subsequently broken. This experience was shared by more than one staff member. Respondents also told us that bullying ensued when patient safety concerns were raised which impacted on the department's ability and willingness to learn from mistakes and innovate.

Staff used the survey to raise concerns about patient care in the cardiothoracic unit, especially around the quality of care and safety concerns. They felt that their usual routes to report feedback were reduced due to intimidation and inaction.

"Valid concerns around staffing issues and effects on patient care were raised but seemed to be overlooked or dismissed."

Respondents told us there are "significant patient safety issues in adult cardiac surgery".

Some felt the Trust does not act upon claims of bullying because of the fear of reputational damage for the Trust if a specialised subject area was brought into disrepute over bullying.

"If credible bullying allegations are made and largely substantiated, and those responsible are key to specialised services, nothing is done, and the bullying victims are those who are punished. I have direct experience of this."

There were also some comments of a culture of discrimination towards women within the Cardiothoracic department. Specifically, there were claims that women were "not promoted" as they were "difficult for the leaders to manage". Whilst comments in the survey related to lack of opportunities for women, we found there were female leaders in a number of senior leadership roles. We were also given some specific examples where female staff had experienced sexually inappropriate behaviours by other members of staff. During the well-led inspection, the trust did tell us they had taken appropriate action in relation to one of incidences.

Comments made directly to CQC were: -

"Women are not seen as important in the department; I was made to feel that I did not count as a human being, they treat all women like that."

"The culture has impacted on my mental health; it took me a long time to realise it wasn't me. Support from certain staff kept me alive".

Following our onsite inspection in July 2023, CQC wrote to the trust about the culture within the cardiothoracic surgery department which included: -

• Concerns raised by staff at all levels and across different professional groups in the service, about the culture and poor bullying type behaviours.

• Of the staff we spoke to, all felt they had suffered a detriment as a result of raising patient safety concerns.

• Staff also described as a result; they were fearful to raise patient safety concerns again. We shared this had also had a wider impact across the organisation, on staff feeling confident to raise concerns.

Surgery

• Concerns shared with CQC from a whistleblower, where in September 2022, there were concerns about cardiothoracic theatres and surgical trainees. Specifically, it stated that "after an incident where trainees felt the atmosphere in cardiothoracic theatres were toxic, and at the very least disrespectful of them, and others."

• A whistleblowing concern that identified there had been a number of professional practice concerns raised about consultants in the last 7 years.

• Concerns raised about sexually inappropriate behaviours in the department.

During a meeting with the executive team as part of the inspection, CQC acknowledged that the trust had had multiple individual circumstances to work through, and that this had been difficult and challenging. Whilst recognising this, as part of this meeting we did discuss the need to focus on the culture of the service now, as this was potentially impacting on patient care, delivery of the service and staff experience. The executive team shared that whilst recognising the need to address the culture within the service, they were concerned that this could lead to some fragility.

Following the well-led inspection, CQC shared concerns about the culture within the department through the stakeholder quality review meeting which included NHS England and the Integrated Care board. Following this, the trust has since updated their action plan which now included specific actions in relation to culture. CQC will continue to monitor progress to ensure the trust continue to focus on improving the culture and psychological safety in the department for staff and reduce the potential impact of a poor culture on patients.

Governance

Whilst there were governance processes in place these were not always operated effectively. Not all staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Concerns were raised with CQC following our onsite inspections about the management and effectiveness of multidisciplinary meetings (MDT) within the department. MDT meetings allow staff to discuss patient's condition and plan care accordingly. Staff described MDT meetings as being ineffectual, where behaviours could impact on clinical decision making and where disagreements were commonplace. As such there was often poor attendance by clinical staff. Whilst this was a concern the trust was aware of; progress was slow, and they had not yet addressed the concerns about MDT meetings. This meant the trust could not be assured that MDT meetings were effective, and that patient care and experience was appropriate.

CQC received information of concern from a whistleblower in relation to a backlog of 'must sign' letters following clinic appointments, patient treatments and operations and inpatient stays. We wrote to the trust on 05 September 2023, using our section 64 powers to request specified information and documentation on this, and we wanted to confirm if this was an issue and the scale of the concern. We were also concerned that this had the potential to lead to delays in patient's receiving appropriate care that would meet their clinical needs, if relevant healthcare practitioners or the patient were not aware of any changes to their condition or treatment.

In their response the trust confirmed this was a known issue in the cardiothoracic department and they had been working to address this since March 2023. The size of the backlog of these letters were detailed as a total of 2,399 dating back to 2019 included in this was 1,196 unsigned letters for 2023.

Surgery

On receipt of the information, CQC further wrote to the trust and sent a letter of intent (section 31) indicating possible urgent enforcement action as we were concerned patients will or may be exposed to the risk of harm. This letter had two specific parts concerns within the cardiothoracic department and trust wide concerns. Particularly for this service we were concerned that: -

• Whilst there had been management oversight and meetings since March 2023, there was still a significant issue in unsigned documentation some 6 months later.

• There was no current service or trust wide standard operating procedure and this was not due to be validated until end of September 2023.

• Furthermore, the trust identified that monitoring would form part of the clinical board's overall assurance improvement action updates. Production of a data extract report to support monitoring and oversight was only due to commence weekly from Monday 18 September.

• The trust provided no evidence of an action plan being developed in March 2023, or that the management team had robust systems to monitor this in the last 6 months.

• Despite being aware for 6 months, the trust had failed to make sufficient progress to reduce the risks to patients.

When we reviewed the surgical risk register that had been provided as part of the core service inspection in June 2023, we found no evidence of this risk on the risk register. Following our focussed inspection in September 2023, we spoke with the cardiothoracic management team and asked specifically why this wasn't on the risk register. The management team described it should have been on the risk register but may not be now as it may have been downgraded.

Following the inspection, we asked for the cardiothoracic risk register and this was not provided. During the factual accuracy period, the trust provided the cardiothoracic surgery risk register which included the risks on the executive oversight register.

During our well-led inspection, we received a copy of the executive oversight register (corporate risk register) for June 2023. We found three risks on there, relating to cardiothoracic services which included: -

• Staffing shortages in the transplant department which was put on the register in July 2021 with an initial score of 25 and a current score of 20.

• The royal college of surgeon's review which was put on the register in October 2021 with an initial score of 25 and a current score of 20.

• Cardiothoracic ITU capacity which was put on the register in June 2023 with an initial score of 20 and a current score of 20.

The trusts risk management policy June 2023 did not identify a specific score for any risk to be escalated to the executive oversight register but did have definitions for risk tolerance (risk appetite) for different areas. It stated that "The Trust supports staff throughout the organisation to manage risk as close to the front line of patient care as possible."

Specifically, it also stated that the oversight register allowed the Executive Team to have oversight of particular risks where:

• Risk owners have communicated the need for additional support.

• Risks which exceed the Risk Appetite Tolerance.

• The risk indicates a significant/increased risk; or

• The risk has the potential to significantly impact a strategic objective.

• Risks held on the Executive Oversight Register continue to be managed at their current level with input and support from the Executive Team where appropriate.

However, we found none of these risks on the surgical core service risk register and were unclear of the mechanisms or governance routes used to escalate these risks to the executive oversight register. We were not assured these risks were managed as close to frontline services as possible or there was sufficient managerial oversight either locally or at executive level to ensure sufficient actions and management of these risks.

The policy also identified that "Clinical Board Management Teams are responsible for ensuring the implementation of the Risk Management Policy within their Clinical Boards including establishing appropriate risk management governance as described in this policy to support the continual management of risks and risk registers." When we spoke with the management team, they acknowledged there was a lot of work they needed to undertake to ensure there were robust governance systems in place.

Following our well-led inspection, we shared our concerns about the cardiothoracic department with NHS England (NHSE) and the Integrated Care Board (ICB), and a quality risk meeting was convened in August 2023. NHSE and the ICB have jointly commissioned a peer review of the service which will be undertaken in the next few months.

Management of risk, issues, and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact.

Following the reporting of the serious incidents in November 2022, an NHS England led quality review meeting was convened in December 2022. At this meeting progress against the Royal college of surgeon's report was reviewed and it was found a number of actions had not been completed. The trust also had had a thematic analysis report that found system wide issues and there were a number of safety recommendations made to improve quality and safety of the service.

CQC requested a focussed engagement meeting to understand how the trust and service were managing this in more detail. At this meeting on 07 February 2023 a number of areas were reviewed including management of the aortic service, management of emergency patients and support to the emergency department, emergency transfer of patients, and managing elective and emergency demand in theatres.

We received some information on these areas about the actions the trust had in place or were undertaking, however, prior to our inspection we received a significant number of concerns regarding culture within the service and patient

safety concerns. We found progress against the action plan had been slow with many of the actions not delivered on time or some actions had not even started. For example, we were told at our engagement meeting in February 2023 that the medical secretaries currently manage the waiting lists with their respective consultants, but the strategy was to centrally manage the waiting lists and this transition was aimed to be completed by June 2023. However, we found as part of our inspection in September that this had not been completed, medical secretaries still managed the cardiac waiting list, and the timeline was possibly November 2023 or even as late as March 2024.

Concerns were raised with CQC about the percutaneous coronary intervention (PCI) rates compared to the coronary artery bypass graft rates (CABG) rates. We were told and sent national data which showed the rates of PCI to CABG for this trust was 30:1, this was significantly higher than national averages of 7.6:1. When we raised this during the during the quality review meeting in August 2023, senior executives told us they were aware of this, but we were unclear on what actions had been taken to date to address this. Subsequently, the trust action plan shared at the beginning of September 2023, identified specific actions in relation to this with a timeline of completion of November 2023.

Some clinical concerns were raised with CQC about training, skills and experience of surgeons undertaking certain types of procedures. We wrote to the trust on 05 September 2023, to ask if the trust had investigated these concerns and to provide an action plan on areas that required improvement. The trust provided details of these on 15 September 2023, we found the action plan detailed the recommendations, actions required and the responsibilities but gave no detail on the timelines for completion. When we inspected on 28 September 2023, we identified concerns relating to acting on the recommendations and spoke with two executive leaders on site to gain further assurances about training, skills, and experience of surgeons. However, we remained concerned that the actions required to address the recommendations had not been fully implemented and the trust did not have appropriate assurances. We spoke to the Chief Executive and wrote to the trust to gain further assurances on 29 September 2023. At the time of writing this report, we will continue to review and monitor information to ensure the trust is taking timely and appropriate action and will do this through our monitoring of the trust.

Information Management

See surgery section in core services report from inspection dated June 2023 for full details.

Engagement

See surgery section in core services report from inspection dated June 2023 for full details.

Learning, continuous improvement and innovation

See surgery section in core services report from inspection dated June 2023 for full details.