Health Education England

St George's University Hospitals NHS Foundation Trust

Cardiac Surgery

Risk-based Review (senior leader conversation)

Quality Review report

5 November 2019

Final report

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Quality Review details

Training programme	Cardiac Surgery
Background to review	The review was planned to follow-up on earlier reviews and work done by Health Education England (HEE) and the General Medical Council (GMC) with the cardiac surgery department. In September 2018 training posts within the department were suspended due to serious concerns relating to the overall learning environment, the ability to provide adequate teaching and supervision and the lack of appropriate caseloads to meet trainees' curricular requirements. In the interim period, the department had worked with a behavioural psychologist with the aim of improving the working relationships and culture within the multidisciplinary team. In addition, NHS Improvement (NHSI) had commissioned an investigation into the high mortality rate of cardiac surgery patients at the Trust. At the time of the review, the publication of this report had been delayed and was anticipated in January 2020.
HEE quality review team	Geeta Menon Postgraduate Dean, South London Health Education England John Brecknell Head of Postgraduate School of Surgery Health Education England, London Samara Morgan Principal Education QA Programme Manager (London) General Medical Council Paul Smollen Deputy Head of Quality, Patient Safety and Commissioning Health Education England, London Gemma Berry Learning Environment Quality Coordinator Health Education England, London Louise Brooker Deputy Quality, Patient Safety and Commissioning Manager Health Education England, London
Trust attendees	The review team met with the following Trust representatives: • Chief Medical Officer • Associate Medical Director for Cardiac Surgery • Associate Director of Medical Education • Divisional Chair.

Conversation details

	Summary of discussions	Action to be taken? Y/N
1	**Departmental culture** The review team was informed that the department had commissioned a psychologist to work with staff and that this psychologist had recently returned to speak to a small number of the clinical fellows. There was a provisional report in place following this work but the Trust representatives were not able to share this until all staff had had the opportunity to read it and confirm its accuracy. There were eight clinical fellows working in cardiac surgery at the time of the review, and the review team was advised that three of them had been interviewed and had given positive feedback about the working environment. The Trust representatives described the department as being very different than it had been two years ago in terms of governance structure, team behaviours and role modelling by consultants. The review leads noted that trainees had previously been largely unconcerned with culture and behaviours, being more focused on the range of experience and learning opportunities available. The Trust representatives acknowledged this but explained that they were not aware of any recent incidents of inappropriate behaviour by consultants and that the increased level of governance had positively impacted the relationships and communication between staff.	Yes, please see action CT1
2	**Serious harm review** The report had been drafted and the relevant clinicians had been sent drafts of the structured judgement reviews for each of the cases they were involved in. There were 208 total cases and there was a one-month period for factual accuracy checking. The review team was informed that the Trust was working to support these clinicians and to ensure that all relevant clinical notes were available in an electronic format so that they were readily accessible if required as evidence. The Trust had written to the families of all deceased patients included in the review and was preparing to follow the duty of candour process where indicated. The most recent National Institute of Cardiovascular Outcomes Research (NICOR) report showed that the mortality rate for patients in the department was no longer above the statistically normal range compared to other cardiac surgery centres and the unit was out of 'alert'. The review leads suggested that the report was likely to have a significant effect on staff in the department and that there would be a period of adjustment following publication. It was agreed that it would not be appropriate to reinstate the training posts until the department had had time to deal with the outcomes of the report.	
3	**Suspended training posts** The cardiac surgery service was staffed by the consultants and clinical fellows following the suspension of training posts in the department. The review team heard that this impacted on rotas, particularly because the fellows were also covering the thoracic on-call rota which made it challenging to cover day shifts in cardiac surgery and to allow the fellows to access a range of clinical experience. The Trust representatives also indicated that the standard of competency among the clinical	

	fellows was not as consistent as among trainees. The department had continued to run a formal teaching programme and the clinical fellows had opportunities to present at multidisciplinary team (MDT) meetings. There was discussion of the potential timeframe for reintroducing trainees to cardiac surgery. The review lead emphasised the need to await the publication of the serious harm review and assess the impact and repercussions of this before placing trainees back into the department. The Head of School enquired about the Trust's plans around reintroducing trainees and how the department would ensure the trainees were protected from the issues arising from the serious harm review. The Trust representatives agreed that it was necessary to protect the trainees while remaining transparent about the outcomes of the review and involving them in any work around lessons learned. The review team heard that trainees would be involved in the work on reporting processes, escalation structures, morbidity and mortality meetings and other forums relating to governance and quality improvement. The Trust planned to implement escalation mechanisms for trainees outside the department. It was suggested that, when it was deemed appropriate for HEE to place trainees in the department again, the Trust would prefer to accept more junior trainees first and continue with the consultants running the complex side of the service while the training posts were gradually re-established. The Head of School requested that the Trust submit a framework document for the reintroduction of training posts to assist HEE in planning this process.	Yes, please see action CT3
4	**Thoracic surgery training** The review team enquired about the cardiothoracic surgery trainees who had remained in the department and were based in the thoracic team. The Trust representatives explained that these trainees worked solely in thoracics and that the trainees were not covering the night on-call rota at present. The review leads clarified that it was acceptable for the trainees to participate in the on-call rota as long as they were not required to cover cardiac surgery, were supervised by thoracic surgeons, had a rota compliant with the current junior doctor contract and were not prevented from accessing learning opportunities during the day. The Head of School noted that feedback from the thoracic trainees was generally positive.	Yes, please see action CT4

Next steps

Conclusion
The Postgraduate Dean acknowledged the work done by the Trust in addressing the cultural concerns and preparing to reinstate training. It was agreed that HEE would conduct a further quality review in April 2020 to meet with representatives of the multi-disciplinary team in cardiac surgery. This would allow HEE to better assess the level of change which had taken place, discuss the impact of the serious harm review and decide whether trainees could be placed in the department from October 2020.

Good Practice and Requirements

Good Practice

The Trust had significantly improved the clinical governance structures and processes in the cardiac surgery department.
The Trust had worked to minimise the impact of issues in cardiac surgery on trainees in thoracic surgery and these trainees had given positive feedback about their experience.

Mandatory Requirements

The most common outcome from a quality intervention. The risk rating must fall within the range of 8 to 12 or have an Intensive Support Framework rating of 2.

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
CT1	The Trust should share the behavioural psychologist's report into culture change in the department.	Please provide a copy of the report when this is available.	R2.11
CT3	The Trust should develop a written framework outlining the plan for reintroducing trainees into cardiac surgery and agree this with HEE.	Please submit a copy of the framework document.	R2.11
CT4	The Trust should send the Head of School for Surgery a copy of the proposed thoracic surgery trainee rota including out of hours work. The trainees' on-call commitment should not include cover for the cardiac surgery service or compromise their ability to access educational opportunities.	Please submit a draft rota.	R1.12

Minor Concerns

Low level actions which the Trust need to be notified about and investigate, providing HEE with evidence of the investigation and outcome. Given the low level nature of this category, the risk rating must fall within the range of 3 to 6 or have an Intensive Support Framework rating of 1.

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
	None		

Recommendations

These are not recorded as 'open' on the Trust action plan so no evidence will be actively sought from the Trust; as a result, there is no requirement to assign a risk rating.

Rec. Ref No.	Recommendation	GMC Req. No.
	None	

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
HEE will plan a follow-up review in spring 2020.	HEE Quality, Reviews and Intelligence team

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Professor Geeta Menon
Date:	16 December 2019

What happens next?

We will add any requirements or recommendations generated during this review to your LEP master action plan. These actions will be monitored via our usual action planning process.