

Cardiac Surgery GIRFT Gold Action Plan – September 2021

For Board

	Goal	Method	Outcome	Lead	Timescale	Update
1.	Mitral Valve Outcomes					
1.1	MV Surgery to be undertaken by Specialist MV Surgeons only	<ul style="list-style-type: none"> All MV referrals into the Cardiac service to be reviewed and under the care of Specialist MV surgeons only Establish complex surgery MDT to assess suitability for MV repair vs MV replacement Letter sent to patients informing them of changes and OP appointments made to discuss moving Consultants 	<ul style="list-style-type: none"> Maintain Patient safety All patients listed for MV surgery under the care of an MV Specialist Combined MDT decision-making for the most appropriate surgery Increase the proportion of MV repair to replacement; target upper quartile peer 	<p>Clinical Director, Cardiothoracic Surgery</p> <p>Clinical Director, Cardiothoracic Surgery</p> <p>Clinical Director, Cardiothoracic Surgery</p> <p>Deputy Group Medical Director, Morriston Hospital</p>	<p>Completed</p> <p>Completed</p> <p>01.01.22</p> <p>Completed</p>	<p>Implemented w/ immediate effect; only 2x surgeons performing MV surgery</p> <p>Mitral Valve MDT established to make surgical decisions on surgery (incl. MV repair vs. MV replacement)</p> <p>A separate High Risk Cardiac Surgical MDT has also been established to discuss all complex, or, high risk cardiac surgical cases</p> <p>7 patients identified; 3 agreed to move and have booked OPA; remainder have been discussed at MDT w/ plans in place</p>

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1.2	Case note review of all patients who died following MV surgery	<ul style="list-style-type: none"> Case note review to be undertaken to establish: <ul style="list-style-type: none"> Correct coding Risk score Pre-Operative risk Post-Operative risk Cause of death 	<ul style="list-style-type: none"> Full clinical review to identify appropriateness for surgery and any contributing factors 	Group Medical Director, Morriston Hospital Service Delivery Unit	1.10.21	Review of 19 cases: Completed. Report to Exec MD by 11.10.21
1.3	Independent external expert to review case notes in conjunction w/ operating surgeon	<ul style="list-style-type: none"> Commission case note review by independent expert 	<ul style="list-style-type: none"> Independent expert to provide opinion on appropriateness for surgery, risk, outcome and factors contributing to death 	Executive Medical Director	February 2022	
1.4	Review Consultant specific outcomes and discussion to be undertaken with individuals	<ul style="list-style-type: none"> Full team outcome review to be undertaken and variation to be discussed with individuals 	<ul style="list-style-type: none"> A reduction of variation within Cardiac Surgery Clinicians' performance meets standards and ensure best outcomes for patients 	Group Medical Director, Morriston Hospital Executive Medical Director	01.11 21	Scheduled to take place in October (along with review of 1.2 with cardiac surgical group)

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2.	Quality						
2.1	Return to Theatre (bleeding)	i)	Clinical case note review undertaken for each patient to establish: <ul style="list-style-type: none">• Risk score• Pre-Operative risk• Post-Operative risk• Reason for return	<ul style="list-style-type: none">• Action plan to address key improvement metric areas	Group Medical Director, Morriston Hospital	31.10.21	
			<ul style="list-style-type: none">• Review findings from case note review at departmental Morbidity and Mortality meeting	<ul style="list-style-type: none">• Shared understanding among clinicians of need for improvement	Group Medical Director , Morriston Hospital	26.11.21	
		ii)	Action plan to be delivered to address areas required for improvement	<ul style="list-style-type: none">• Target reduction of return to theatre to upper quartile in peer group of 31 units	Clinical Director, Cardiothoracic Surgery	13.10.21	Intraoperative checklist has been developed (attached) and will be completed for each patient from w/c 16/08; post implementation this will be continually audited and discussed via M&M meetings on a monthly basis in the first instance moving to quarterly (assurance permitting)

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						<p>return to theatre. Thus, the reported DSWI rate is recorded as $9/1890 = 0.48\%$</p> <p>According to GIRFT criteria, 41 patients had a “deep sternal wound infection” i.e. 2.17% [2.12% was stated in the report]. However, this captured <u>all</u> patients who had:</p> <ul style="list-style-type: none">i) a <u>superficial</u> wound infection treated with a Vac pumpii) a deep sternal wound infection treated with a Vac pump but without surgical debridementiii) a deep sternal wound infection who required surgical debridement (i.e. the NICOR definition) <p>The 41 patients have been reviewed by the senior nursing team (LJ) and the respective numbers (%) in these categories are:</p>

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	Goal	Method	Outcome	Lead	Timescale	Update
		<ul style="list-style-type: none"> Benchmark against <i>Guy's and St Thomas'</i> (current infection rate: 0.27%) 	<p>undertaken and LocSSIPs updated</p> <ul style="list-style-type: none"> Audit current practice against infection control and antibiotic guidelines during August 21 Review options to reduce infection rate via using dressing laced with gentamicin 	<p>Cardiothoracic Surgery</p> <p>Lead Intensivist, Cardiothoracic Surgery</p> <p>Consultant, Cardiothoracic Surgery</p>	<p>Completed</p> <p>31.10.21</p>	<ul style="list-style-type: none"> WHO checklist in theatre uniform draping technique in theatre use of chlorhexidine skin preparation <p>To be picked up in benchmarking discussions with Guy's and St Thomas'</p> <p>Immediate actions taken to provide assurance on safety are:</p> <ul style="list-style-type: none"> Consultant only operating audit IPC compliance in Aug/Sept along with compliance w/ antibiotic guidelines reinforce process and guidelines for pre op preparation of the patient and ward based pre op checks

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	Goal	Method	Outcome	Lead	Timescale	Update
						Plan to implement review of individual cases of deep sternal wound infection (DSWI) via multidisciplinary team, led by a consultant microbiologist
2.3	Post-operative Neurological Deficit	<ul style="list-style-type: none"> Internal case note review to be undertaken for each patient to establish: <ul style="list-style-type: none"> Risk score Pre-Operative risk Post-Operative risk Intraoperative risk Action plan to be developed in response to findings Delivery of action plan Monitoring improvement 	<ul style="list-style-type: none"> Understanding of where improvements can be made Set goals for improvement upper quartile peer Deliver action plan for improvement Ensure improvement is sustainable 	<p>Group Medical Director, Morriston Hospital/Clinical Director, Cardiothoracic Surgery</p> <p>Clinical Director, Cardiothoracic Surgery</p> <p>Clinical Director, Cardiothoracic Surgery</p>	<p>01.11.21</p> <p>23.11.21</p> <p>30.11.21</p> <p>TBC</p>	<p>Data extracted and shared with UMD w/c 02/08/2021</p> <p>Immediate actions taken to provide assurance on safety are:</p> <ul style="list-style-type: none"> Consultant only operating Preop: patients at risk (pre-existing premorbid conditions) identified by surgeon and appropriate risk quoted + documented Intra-op: Full invasive monitoring, appropriate support of perfusion pressures on CPB and afterwards. The length of CPB and aortic cross clamp time might be difficult to

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						<p>predict as it can depend on the patient's anatomy</p> <ul style="list-style-type: none"> Post-op: Level 3 care in CITU + support of organ systems as necessary to prevent and support AKI. Involvement of nephrology team in event of AKI requiring CVVHD. Neurology team + stroke team for advice on management of CNS complications and rehabilitation
2.4	Post-operative Dialysis	<ul style="list-style-type: none"> Internal case note review to be undertaken for each patient to establish: <ul style="list-style-type: none"> Risk score Pre-Operative risk Post-Operative risk Action plan to be developed in response to findings 	<ul style="list-style-type: none"> Understanding of where improvements can be made Set goals for improvement upper quartile peer 	<p>Group Medical Director, Morriston Hospital</p> <p>Clinical Director, Cardiothoracic Surgery</p>	<p>01.11.21</p> <p>30.11.21</p>	<p>Data extracted and shared with UMD w/c 02/08</p> <p>Immediate actions taken to provide assurance on safety are:</p> <ul style="list-style-type: none"> Consultant only operating Preop: patients at risk (pre-existing premorbid conditions) identified by surgeon and appropriate risk quoted + documented

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		<ul style="list-style-type: none"> Delivery of action plan Monitoring improvement 	<ul style="list-style-type: none"> Deliver action plan for improvement Ensure improvement is sustainable 	<p>Clinical Director, Cardiothoracic Surgery</p> <p>Clinical Director, Cardiothoracic Surgery</p>	<p>30.11.21</p> <p>TBC</p>	<ul style="list-style-type: none"> Intra-op: Full invasive monitoring, appropriate support of perfusion pressures on CPB and afterwards. The length of CPB and aortic cross clamp time might be difficult to predict as it can depend on the patient's anatomy Post-op: Level 3 care in CITU + support of organ systems as necessary to prevent and support AKI. Involvement of nephrology team in event of AKI requiring CVVHD. Neurology team + stroke team for advice on management of CNS complications and rehabilitation




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		<ul style="list-style-type: none"> Deliver a plan to implement the change 		Senior Matron, Cardiac Surgery	31.11.21	<p>Link in developments w/ the Draft all Wales pathway:</p>  <p>All Wales Pathway Final Draft -anaemia</p> <p>Plans are being developed to provide additional space for pre assessment in Cardiac OPD which will provide the space for enhanced pre admission; this will align with a plan to utilise the Theatre Admission Unit to support improved pre admission anaemia management</p>
3.	Processes & Patient Pathway					

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		list; 2nd patient to be DOS admission		Cardiothoracic Surgery		
3.2	Discharge Processes	<ul style="list-style-type: none"> Benchmark against Basildon and Thurrock University Hospital, Barts Health and upper quartile peer group for post op length of stay (LOS) to support improvement in post op LOS Development of patient admission and discharge SOP following benchmark review to include: <ul style="list-style-type: none"> ERAS pathways Weekend discharge plans Role of daily senior decision maker Options for nurse led discharge Role of board rounds in effective discharge planning 	<ul style="list-style-type: none"> Identify best practice that could be implemented locally Reduced post op LOS stay to upper quartile performance in peer group of 31 units through examination of current causes of delay Standardised processes adopted within the unit and reduced post op LOS stay to upper quartile performance in peer group of 31 units Implementation of key changes Monitoring via CD/Service Group MD 	<p>Senior Matron, Cardiac Surgery</p> <p>Senior Matron, Cardiac Surgery</p> <p>Senior Matron, Cardiac Surgery</p> <p>Clinical Director,</p>	<p>31.10.11</p> <p>31.10.11</p> <p>14.11.21</p> <p>Oct 21 onwards</p>	<p>Clinical Director, Cardiothoracic Surgery to discuss w/ colleagues to agree to remove wires on weekend to support weekend discharge; link in w/ plan for 7 day working for echocardiography to support post removal echo on the weekend</p> <p>Reissue the SOP for post op care of cardiac surgery patients</p> <p>Agree inclusion criteria</p> <p>Ensure weekend plans are fully worked up and discussed in Fri Board Rounds</p>

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		<ul style="list-style-type: none"> Utilisation of Estimated Date Discharge 	and Directorate/Service Group governance processes	Cardiothoracic Surgery		
3.3	Critical Care LOS Note: currently the unit has 12 CITU beds and not 20 identified in the GIRFT review. The remaining 8 beds are used to support “green” pathway for non-cardiac elective surgery	<ul style="list-style-type: none"> Review utilisation of CC capacity to ensure appropriate step-down into lower level beds 	<ul style="list-style-type: none"> Target of no patients discharged home from a designated critical care bed 	Senior Matron, Cardiac Surgery	Completed	Utilisation and availability of beds on Dan Danino and Cyril Evans being monitored and DTOC process agreed for CITU/HDU Daily Cardiac Safety Huddle has been established (chaired by Senior Matron) to support appropriate allocation of beds
3.4	Ratio of Urgent: Elective cases	<ul style="list-style-type: none"> Demand/capacity exercise to be undertaken for elective and IP work to facilitate meaningful planning Benchmark against University Hospital 	<ul style="list-style-type: none"> Capacity aligned to service requirements that will support achievement of WHSSC LTA target Immediate increase in throughput linked to maximising waiting lists to achieve monthly rate of activity consistent with contracted activity 	Directorate Manager, Cardiac Surgery Directorate Manager, Cardiac Surgery	Completed Completed	Capacity Planning Meeting has been set up on a Tue and Thu to support improvement Locum Consultant in post and undertaking additional theatres; job planned for 2x all day theatres p/wk w/ additional backfill as necessary

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		Southampton Cardiology unit to understand their zero tolerance approach to cancellations	<ul style="list-style-type: none"> Explore feasibility of pooling non-elective cases ready for next available theatre and next available appropriate surgeon 	Clinical Director, Cardiothoracic Surgery	14.10.21	Discussion has taken place and plan is supported; implementation plan currently being worked up
3.5	Weekend Operating Lists	<ul style="list-style-type: none"> Keep under review – not required currently – focus on delivering full available capacity during core hours 	<ul style="list-style-type: none"> Monitor requirements – If all core capacity is fully utilised and additional capacity is still required this will be reviewed 	Directorate Manager, Cardiac Services	Completed	With the availability of 8x 3 session operating days per week there is capacity to deliver activity of 13-15 cases per week; there is not the demand to justify weekend working in addition to this; Further review of demand/capacity being completed to determine if LTA target is realistic
3.6	Timeframe to get back to core pre COVID activity – Elective/Emergency Surgery	Identify constraints and work through solutions: <ul style="list-style-type: none"> Bed capacity Pre/Post admission 	<ul style="list-style-type: none"> Pre-core activity re-established for 2019/20 on monthly rate 	Directorate Manager, Cardiac Services	Completed	Capacity meeting on Mon & Thu being used to closely monitor and maximise the amount of surgical activity; there are constraints w/

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		<ul style="list-style-type: none"> Green/Amber Pathway theatre capacity Staffing resources 	<ul style="list-style-type: none"> Activity increased to deliver WHSSC contracted activity 	Directorate Manager, Cardiac Services	01.11.21	theatre scrub staff, anaesthetics and critical care capacity that will become more problematic as capacity further increases
3.7	Implementation of Component Wait for Cardiac Surgery	<ul style="list-style-type: none"> Waiting times report created similar to TAVI to allow transparency of the Cardiac Surgery waiting time element of the pathway 	<ul style="list-style-type: none"> Transparent Cardiac Surgery component waiting time to monitor performance and bottlenecks 	Directorate Manager, Cardiac Services	31.03.22	SBUHB has been trialling a new aggregate report as an interim measure until a patient level MDS is created to support component waiting times; plan in place to shadow report with a view to formally reporting from 01.04.22
4.	Governance and Assurance					

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4.1	Clinical Outcomes Data	<ul style="list-style-type: none"> Establish a formal Standard Operating Procedure on cardiothoracic data validation, risk adjustment, outlier identification, escalation plans and reporting for GIRFT metrics Development of module within HB PATS – Discuss with Informatics colleague Review and discussed at monthly clinical audit; Increase collaboration between clinical cardiothoracic team and coders by including coders in MDT meetings and morbidity and mortality meetings Publish outcome and improvements via bi-monthly Cardiac Surgical Board 	<ul style="list-style-type: none"> Improve quality and safety within the service Transparent monthly outputs - any concerns with the performance of the service will be clearly visible/monitored and discussed in the various fora Transparency regarding clinical outcomes 	<p>Deputy Group Medical Director, Morriston Hospital</p> <p>Consultant Cardiothoracic Surgeon</p> <p>Clinical Director, Cardiothoracic Surgery</p>	<p>01.10. 21 In line w/ dates of Audit and Board mtgs.</p> <p>In line w/ dates of Audit and Board mtgs.</p>	Format of quality metrics report being worked through following discussions with IM&T colleagues

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4.2	Reporting and Escalation Framework	<ul style="list-style-type: none"> Publish outcome and improvements via Morriston Service Delivery Group's Quality & Safety Group 	<ul style="list-style-type: none"> Report to be completed and discussed in Morriston Service Delivery Group's Quality & Safety Group 	Clinical Director, Cardiothoracic surgery	Completed	Consultant Surgeon & Audit Lead for cardiac surgery attending Morriston SG Q&S Group and providing updates on cardiac surgery outcomes as part of the governance report
4.3	Development of Clinical Outcomes Dashboard	<ul style="list-style-type: none"> Refine annual NICOR data to provide more granularity on a range of outcome measures Discuss with informatics colleagues options for live dashboard with ability to monitor clinical outcomes in real-time 	<ul style="list-style-type: none"> Will enable a comparison with internal and GIRFT data to sense check and monitor for accuracy Dashboard developed for regular use within the service to allow for a monitoring mechanism to inform quality and activity improvements and report quality measures 	Clinical Director, Cardiothoracic Surgery Deputy Group Medical Director, Morriston Hospital	Completed 01.11.21	
4.4	Data Submissions to NICOR	<ul style="list-style-type: none"> Review current process for submitting data via clinical team and clinical audit coordinator to ensure sufficient capacity in place 	<ul style="list-style-type: none"> Unified approach and clinical consensus/educational requirements addressed 	Clinical Director, Cardiothoracic Surgery	Completed	

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		<ul style="list-style-type: none"> Review of audit coordinator provision to assess if current resource is sufficient 	<ul style="list-style-type: none"> Resource requirement to cover the current single handed audit coordinator to be identified 	Directorate Manager, Cardiac Surgery	Completed	A workload review has been concluded and discussions taking place on the resources required moving forward; benchmarking against units of a similar size is also underway to support the process
4.5	Develop clear and robust governance framework to ensure Directorate and Service Group are sighted on key performance and outcome metrics (including morbidity as well as mortality)	<ul style="list-style-type: none"> Key quality metrics to be discussed at each directorate M&M meeting and action plans developed to address variance Service Group to receive monthly summary of outcome data for Service Group Q&S meetings; oversight of actions being taken within directorate 	<ul style="list-style-type: none"> Ownership of outcomes (morbidity as well as mortality) by clinicians Develop culture of constant improvement 	<p>Clinical Director, Cardiothoracic Surgery</p> <p>Group Medical Director, Morriston Hospital</p>	<p>Completed</p> <p>01.11.21</p>	<p>Weekly Triumvirate (CD, DM & SM) Meeting established to provide operational oversight of the implementation of the GIRFT Gold Action Plan</p> <p>Project management structure has been agreed in line w/ Gold/Silver/Bronze Command and Control Structure</p> <p>Audit Lead for cardiac surgery attending Morriston SG Q&S Group and providing updates on cardiac surgery outcomes as part of the governance report</p>