Meeting Date	**28 September 2021**	**Agenda Item**	**2.1**
Report Title	**Progress report on the review of cardiac services improvement plan**		
Report Author	Dr Richard Evans		
Report Sponsor	Mark Hackett		
Presented by	Dr Richard Evans		
Freedom of Information	Open		
Purpose of the Report	• To update the Health Board on the Getting it Right First Time (GIRFT) report on the Cardiac Surgery service at Swansea Bay UHB. • To give assurance on the range of actions taken, the improvement plan in progress, and key deliverables.		
Key Issues	• The GIRFT report noted that overall mortality from cardiac surgery was consistent with the UK national average. • Concerns were expressed about mortality from mitral valve surgery, several quality indicators, and clinical pathway/process issues. • An improvement plan has been developed in conjunction with WHSSC and agreed. • The Executive Medical Director is seeking input from the Royal College of Surgeons and Society for Cardiothoracic Surgery to advise on quality governance and to undertake a review of casenotes of patients who died following mitral valve surgery to establish any improvements to practice. • The report, actions taken to date, and the improvement plan have been shared with key stakeholders.		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☒
Recommendations	Members are asked to: • **NOTE** the report • **APPROVE** the approach and action plan for the Executive Medical Director to implement with the Morriston Hospital Service team		

	• **APPROVE** The role of Quality and Safety Committee in the oversight of the implementation of the improvement plan **<u>Items for information will not be allocated time for consideration within the Board/Committee meeting.</u>**

PROGRESS REPORT ON ACTIONS TAKEN IN RESPONSE TO GIRFT REPORT ON CARDIAC SURGERY

1. INTRODUCTION

Cardiac surgical services in Wales are commissioned by the Welsh Health Specialised Services Committee (WHSSC) and are undertaken at two centres: the University Hospital of Wales in Cardiff and Morriston Hospital in Swansea Bay UHB (SBUHB).

2. BACKGROUND

WHSSC commissioned Getting it Right First Time (GIRFT) to review both services in Wales due to a concern about health boards meeting their commissioned figures for procedures undertaken. GIRFT presented their findings to SBUHB at the end of June 2021. The GIRFT team:

- Observed that Morriston is a small cardiac unit (29th of 31 centres in England and Wales) and performs the second-lowest number of aortovascular procedures per year in England and Wales

- Reported that the overall outcome (mortality) of cardiac surgery is consistent with the average for England and Wales

- Raised specific concerns and made recommendations about our outlier status in four aspects - quality metrics, mitral valve surgery outcomes, patient pathway and process issues (bed occupancy, length of stay and waiting times), and aortovascular surgery (a pan-Wales issue).

- Quality metrics: there were higher observed rates of Deep Sternal Wound Infection; return to theatre following surgery (for all cause and for bleeding); post-operative neurological dysfunction; post-operative renal dysfunction; and a higher than expected mortality for mitral valve surgery.

Outcomes and quality measures for all cardiac services in the UK are collated and published through the annual National Adult Cardiac Surgery Audit (NACSA). This national audit, which publishes data for three consecutive years, is undertaken through data submitted from each surgical centre through the National institute for Cardiovascular Outcomes research (NICOR). Some of the data presented by GIRFT differs from the outcomes for the Morriston unit that are presented in the NACSA audit and the reasons for these differences are being explored further.

Actions taken

<u>Immediate actions taken</u>

GIRFT recommended that all surgery should only be undertaken by consultants and that all mitral valve surgery should only be undertaken by the two mitral valve specialists. These recommendations were put in place immediately by the Executive Medical Director.

Executive oversight

The Executive Medical Director has convened a Gold command to oversee the development of a comprehensive action plan. A Silver command structure has been established in the Morriston Service Group, comprising clinical and managerial leads from the Service Group and cardiac surgical service.

An action plan has been developed in conjunction with WHSSC to ensure that the identified actions address the issues raised in a timely way (Appendix 1). WHSSC are holding 6-weekly escalation meetings with the Health Board in order to oversee the implementation of the action plan.

The service is undertaking a review of the outcomes reported by GIRFT and comparing these with the NACSA audit to ensure that the service is reporting data according to the consistent definitional criteria.

In reviewing the data for deep sternal wound infection (DSWI), it has been established that 12 of 1890 (0.63%) patients in SBUHB who had cardiac surgery in SBUHB had a DSWI infection following surgery. This compares with 0.65% as the national average in cardiac services in the UK. The rate of infection differs significantly to that reported by GIRFT (2.12%) because different definitions were applied that do not allow comparison to the national average.

Support from the Royal College of Surgeons and Society for Cardiothoracic Surgery

The Executive Medical Director has also discussed the report with the President of the Society of Cardiothoracic Surgery and with the Royal College of Surgeons (RCS), and will commission an Invited Review of the service, with the aim of advising on best practice in relation to quality governance and an aspiration for continuous service improvement; and to undertake a casenote review of the patients who died following mitral valve surgery to determine whether these

Communication

The report and the action plan has been shared with Welsh Government, Healthcare Inspectorate Wales (HIW), Audit Wales, and the Ombudsman. Executive colleagues in other health boards (Hywel Dda, Powys, Cwm Taf Morgannwg, Cardiff and Vale) have also been informed.

The Health Board will be contacting the families of the patients who died following mitral valve surgery to inform them that further investigation into their deaths will be taking place and to offer the opportunity to discuss the care of their relative.

3. GOVERNANCE AND RISK ISSUES

The immediate actions put in place on GIRFT and WHSSC's recommendations are aimed to mitigate risk in mitral valve surgery. The Executive Medical Director has

requested further data regarding individual consultant's outcomes to assure himself that these measures are sufficient.

Regular 6-weekly escalation meetings have been arranged so that WHSSC can be assured of the timely actions being taken.

Updates on progress have been provided to the Quality and Safety Committee.

4. FINANCIAL IMPLICATIONS

There are no direct financial implications following receipt of the report.

5. RECOMMENDATION

The Health Board is asked to note the report, and to approve the actions being taken as described in the improvement plan.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☐
	Timely Care	☒
	Individual Care	☐
	Staff and Resources	☐
Quality, Safety and Patient Experience		
The GIRFT report highlights concerns regarding quality, safety and patient experience. The actions being taken will address these comprehensively.		
Financial Implications		
No direct financial implications following receipt of the report.		
Legal Implications (including equality and diversity assessment)		
Currently not thought to be any legal implications		
Staffing Implications		
No direct implications following receipt of the report.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
None		

Report History	Previous verbal update to Board In-Committee 29/07/2021 Report to Quality & Safety In-Committee 24/08/2021
Appendices	Appendix 1 - Cardiac Surgery Action Plan