Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Reference Number: FOI202324/147
From: Private Individual

Date: 13 June 2023

Subject: Royal College Reports

Follow up request relating to FOI202324/071 – “Royal College Reports”

Q1 Please can you provide a copy of the 2022 joint review with NHS England following a Freedom to Speak Up concerning surgical outcomes

A1 Information exempt under Section 21 of the Freedom of Information Act 2000 - ‘Information reasonably accessible to the applicant by other means’.

This information is available on our website, it can be found in our 2022/23 Disclosure Log, please see FOI Request Ref: 410:
http://www.lhch.nhs.uk/about-lhch/information-governance/freedom-of-information/disclosure-logs/

Enter the year into the **Category field** and reference number into the **Title field** then click Search. Select Download to open.

Q2 Please can you provide a copy of the Royal College Report undertaken in 2019 concerning a specific clinicians practice. Please provide a redacted report to redact patient confidential information. In the alternative, please provide the findings / recommendations of the Royal College Report undertaken in 2019 concerning a specific clinicians practice

A2 Please see attachment *FOI202324 147 Response* for a copy of the recommendations of the report.

Some information has been redacted under exemption Section 40: Personal data. Providing this information would likely identify individuals involved.

5. Recommendations

5.1. Urgent recommendations to address patient safety risks

The recommendations below are considered to be highly important actions for the healthcare organisation to take to ensure patient safety is protected.

1. The Trust should ensure that when [redacted] is on-call, there is at least one other consultant colleague available should the urgent need for assistance arise. The review team concluded that the risk of complications arising in surgery is too high for [redacted] to be operating without access to assistance as required.

2. The review team recommends that the Trust follow up patient A4, to ensure that they have continued to receive the appropriate care. In particular the review team wished to highlight the risk of a possible complication in the longer term in relation to the patient's aortic valve

5.2. Recommendations for individual performance improvement

The following recommendations are considered important actions to be taken by [redacted] and the healthcare organisation in order to improve patient care.

3. The Trust should work with [redacted] to ensure that the cases where [redacted] is to operate are selected carefully. Based on the CUSUM curve data the review team would suggest that single valve replacements are safe for [redacted] to continue to perform. Isolated CABG procedures may also be appropriate, but given the specific CUSUM curve data for these procedures, some further consideration of individual cases is warranted. The review team would recommend that some further criteria be set, with [redacted] perhaps being required to discuss more complicated isolated CABG procedures with a colleague pre-operatively.

4. The Trust should ensure that there is close, ongoing monitoring of [redacted] outcomes, including individual instances of mortality and morbidity as well the CUSUM curves. Any trends or incidents, giving cause for concern, should be promptly responded to.

5. The review team agreed that [redacted] seems to sit outside of the subspecialty teams that make up the service, and therefore may miss out on the benefits of working within a tight-knit team environment. The review team suggests that the Trust considers appointing a buddy colleague for [redacted] to help [redacted] develop closer working relationships with [redacted] colleagues.

6. The review team strongly advises that [redacted] is scrubbed and present in theatre for all procedures [redacted] delegates to trainees. The review team feel that this should be of high personal importance to [redacted] due to the effect that an adverse incident can have on [redacted] performance data, and also due to [redacted] reputation within the Trust as a trainer.

7. At this time, the review team strongly advises that [redacted] not be involved in the introduction of new techniques.

5.3. Recommendations for Service Improvement

The following recommendations are considered important actions to be taken by the healthcare organisation to improve the patient care provided by the service.

8. The review team strongly suggests that the Trust's performance management processes are reviewed. The Trust should ensure these processes include the setting of clear goals and timescales so that individuals involved fully understand what they need to achieve and by when.

9. The review team suggests that the Trust requires all consultants to follow a standardised theatre briefing process, setting out the minimum requirements for what is expected. The review team also suggests that the Trust should encourage all consultant surgeons to conduct a debrief session following surgery. This will afford the opportunity to discuss any issues encountered during operating.

5.4. Responsibilities in relation to this report

This report has been prepared by The Royal College of Surgeons of England and the Society for Cardiothoracic Surgery under the IRM for submission to the healthcare organisation which commissioned the invited review. It is an advisory document and it is for the healthcare organisation concerned to consider any conclusions and recommendations reached and to determine subsequent action.

It is also the responsibility of the healthcare organisation to review the content of this report and in the light of these contents take any action that is considered appropriate to protect patient safety and ensure that patients have received communication in line with the responsibilities set out in the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Regulation 20.[13]

5.5. Further contact with the Royal College of Surgeons

Where recommendations have been made that relate to patient safety issues the Royal College of Surgeons will follow up with the healthcare organisation that commissioned the invited review to ask it to confirm that it has taken to action to address these recommendations.

If further support is required by the healthcare organisation The College may be able to facilitate this. If the healthcare organisation considers that a further review would help to assess what improvements have been made the College's Invited Review service may also be able to provide this assistance.

[13] The Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014: http://www.legislation.gov.uk/uksi/2014/2936/contents/made