Cardiac Surgery GIRFT Gold Action Plan March 2022

	Goal	Method	Outcome	Lead	Timescale	Update	Review/Update of implemented improvements
1.	**Mitral Valve Outcomes**						
1.1	MV Surgery to be undertaken by Specialist MV Surgeons only	• 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	• 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 • Discuss options for a national formal policy for complex and very high-risk cases • Increase the proportion of MV repair to replacement; target upper quartile peer	A Zaidi, Clinical Director, Cardiothoracic Surgery A Zaidi, Clinical Director P Kumar, Deputy Unit Medical Director, Morriston Hospital A Zaidi, Clinical Director	01.7.21 Achieved 01.01.22 26.7.21 30.09.21	Implemented w/ immediate effect; only 2x surgeons performing MV surgery **Completed** Complex MDT been established to make surgical decisions on surgery (incl. MV repair vs. MV replacement) **Completed** Dual surgeon operating mandated for complex cases to improve outcomes **Completed** 7 patients identified; 3 agreed to move and have booked OPA; remainder have been discussed at MDT w/ plans in place. **Completed**	Now 3 Surgeons Update required and SOP sign off AZ 5/7 original patients have been operated on. Remaining 2, 1 has declined surgery during the pandemic and 1 required further workup which has now been completed.

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1.2	Case note review of all patients who died following MV surgery • *MV only - 3 deaths in 47 patients overall (6%)* • *MV surgery incl.dual valve – 16 deaths in 119 cases (14%)*	• Case note review to be undertaken to establish: ○ Correct coding ○ Risk score ○ Pre-Operative risk ○ Post-Operative risk ○ Cause of death	• Full clinical review to identify appropriateness for surgery and any contributing factors	M Ramsey, Unit Medical Director, Morriston Hospital Service Delivery Unit	1.10.21	Stage 2 reviews already undertaken which will support the process. 23.11 MR confirmed report completed and sent to MH & RE **Completed** MVR High Risk MDT implemented, outcome decision documented on Solus, **Completed**	Solus being updated with MDT outcomes.
1.3	Independent external expert to review case notes in conjunction w/ operating surgeon	• Case note review by independent expert	• Independent expert to provide opinion on appropriateness for surgery, risk, outcome and factors contributing to death. • Implement actions to deliver key changes identified.	R Evans, Executive Medical Director A Zaidi, Clinical Director	Completion of case note review tbc dependent on RCS/SCTS process When expert review concludes	R Evans has discussed with President SCTS. Documentation completed and submitted. On site review scheduled for the 28-30th March	
1.4	Review Consultant specific outcomes and discussion to be undertaken with individuals	• Full team outcome review to be undertaken and variation to be discussed with individuals	• A reduction of variation within Cardiac Surgery • Improvement in specific outcomes	M Ramsey, Unit Medical Director	01.10.21	Data presented 3 monthly in Clinical Audit by Prof Bhatti, Audit Lead, as per recommendation by RCS **Completed**	

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		• The need for review of individual practice to be discussed with Society of Cardiothoracic Surgery	• Clinicians' performance meets standards and ensure best outcomes for patients	R Evans, Executive Medical Director	01.08.21		
	Goal	**Method**	**Outcome**	**Lead**	**Timescale**	**Update**	
2.	**Quality**						
2.1	Return to Theatre (bleeding)	i) Clinical review of PATS data undertaken for each patient to establish: • Risk score • Pre-Operative risk • Post-Operative risk • Reason for return	• Action plan to address key improvement metric areas	M Ramsey, Unit Medical Director	31.12.21	Analysis of data undertaken by Dr Sameena Ahmed to review trend which will inform further discussions	Meeting scheduled monthly with the Cardiac Surgeons & Anaesthetic colleagues to focus on Quality specific outcomes. **Schedule** 15/3 – Post Operative Neurological deficits 6/4 – Renal Complications 19/5 – Post Operative Would Infections **17/6 – Return to theatre (bleeding)**
		• Review findings from case note review at departmental Morbidity and Mortality meeting	• Shared understanding among clinicians of need for improvement	M Ramsey, Unit Medical Director	14.2.2022		
		ii) Action plan to be delivered to address areas required for improvement	• Target reduction of return to theatre to upper quartile in peer group of 31 units	A Zaidi, Clinical Director	1.09.21	Intraoperative checklist has been developed (attached) and will be completed for each patient from w/c 16/08; post implementation this will be continually	

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						audited and discussed via M&M meetings on a monthly basis in the first instance moving to quarterly (assurance permitting) Mr Sharma is in the process of completing a 6 month audit on blood usage/ return to theatre *CITU closed sampling which stops the blood being lost already in place* **Completed**	Mr Sharma original paper to be uploaded & await outcome of audit to inform discussions at a later date
2.2	Deep Sternal Wound Infection i) Establish definition service is measuring against via NICOR/GIRFT	• Assurance required that cases are being coded correctly on PAT system. All surgeons to complete and sign off operation notes • Case note review of all patients in GRIFT/NICOR dataset reported as deep sternal wound infection to ensure they	• A unified approach and clinical consensus/educational requirements to be addressed • Establish other potential causative factors via case note review, to include: time on bypass,	A Zaidi, Clinical Director M Ramsey, Unit Medical Director	01.9.21 06.9.21	M Ramsey, UMD, has discussed with Nick Dunkley in GIRFT, further clarification on definitions obtained **Completed** Clinical review has been undertaken by M Ramsey; cases already discussed in Surgical	The sternal wound infection data was scrutinised, we established that the rate of infection stated in the GIRFT report included superficial wound infections treated with a Vac pump had been incorrectly attributed as a "deep sternal wound infection", but these would not have fulfilled the criteria for a DSWI in NICOR. The superficial rate was 1.53% and deep SWI rate was 0.63%.

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		meet the established definition	breakdown by Consultant and procedure type			audit (monthly), covering: • Risk score • Pre-Op risk • Post-Op risk Review has been undertaken and data is not correct (MR to write this up). **Completed** Wound risk assessment tool to identify patients at high risk of developing wound infection implemented. **Completed** Retrospective Audit to be undertaken to measure usage Jan 21-Dec 21 . IPC to share list of patients undergone wound swabs to assist with audit	Baseline data Jan 21 – Dec 21 from wound clinic attendances obtained – 415 attendances in total during the period – data to be scrutinised to look for common themes
2.3	ii) Deliver action plan to address key areas for improvement	• Target reduction in deep sternal wound infection in line w/ best practice.	• Achieve best practice wound infection rate: ○ All DSWI <1% (Morriston 1.86% 2017/18 to 2.5% 2018/19)	A Zaidi, Clinical Director	01.09.21	Society of Cardiothoracic Surgeons (SCTS) is working towards consistent definitions for all morbidity, the	

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		• Benchmark against ***Guy's and St Thomas'*** (current infection rate: 0.27%)	○ DSWI R toT <0.25% (Morriston Range 0.31% 2017/18 to 0.18% 2019/20) • Review of intra operative theatre processes being undertaken and LocSSIPS updated. • Audit current practice against infection control and antibiotic guidelines during surgery.	S Ahmed, Lead Intensivist S Ahmed, Lead Intensivist	14.09.21 31.08.21 31.08.21	national audit lead meeting in September 2021 will be by attended by the Clinical Director. ○ CWHO checklist in theatre ○ uniform draping technique in theatre ○ use of chlorhexidene skin preparation ***Literature review on infection control measures for prevention of DSWI following Cardiac Surgery below*** ***Complete*** Immediate actions taken to provide assurance on safety are: ○ Consultant only operating ○ audit IPC compliance in Aug	Ask Stewart Down to establish whether an audit can be undertaken of Intra Operative LocSSIPS , documentation and completeness Awaiting uniform draping technique policy – MP ask SD Chlorhexidine sticks to be considered – Rep visit arranged with surgeons for 15/3 Single use bottles of Chlorhexidine solution initiated in Jan 22 **Pre Op skin preparation as recommended in NICE guidelines** 1.11.21 - Implemented use of Chlorhexidine wipes for skin preparation on the ward prior to procedure instead of Chlorhexidine solution – Confirmed usage on DDW awaiting feedback from other areas 1.12.21 – Pre op clipping to be performed as close to theatre time as possible, therefore first patient on list clips in the morning not evening before. **SOP Below**

			• Review options to < infection rate via using dressing laced with gentamicin.	F Bhatti, Consultant		along with compliance w/ antibiotic guidelines. reinforce process and guidelines for pre op preparation of the patient and ward based pre op checks MDT discussion to be undertaken for all patients who develop deep sternal wound infections. Investigation tool developed to capture case review detail **Completed** Follow up meeting arranged with SSI Lead from Guys & St Thomas – 11.1.2022. **Completed**	All DSWI are to be inputted into Datix, 3 patients identified June 21– December 21, deep dive undertaken on the 13.1.22 **Minutes of Wound infection meeting 7.10.21** **Minutes SSI Meeting – Guys & St Thomas 14.10.21** Recognised that SSI collection process is required. GH liaising with Nurse Director & IPC colleagues to discuss SSI throughout the hospital Surgical site infection audit/surveillance tool has been developed by Gwen Hall, awaiting sign off. ***Upload document once approved***

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2.4	Post-operative Neurological Deficit	Clinical review of PATS data undertaken for each patient to establish: • Risk score • Pre-Operative risk • Post-Operative risk • Action plan to be developed in response to findings • Delivery of action plan • Monitoring improvement	• Understanding of where improvements can be made • Set goals for improvement upper quartile peer • Deliver action plan for improvement • Ensure improvement is sustainable	M Ramsey, Unit Medical Director A Zaidi, Clinical Director A Zaidi, Clinical Director A Zaidi, Clinical Director	01.10.21 29.10.21 30.11.21 31.12.21	Data extracted and shared with UMD w/c 02/08 Immediate actions taken to provide assurance on safety are: ○ 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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						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. *Analysis of data undertaken by Dr Ahmed to review trend which will inform further discussions*	Meeting scheduled monthly with the Cardiac Surgeons & Anaesthetic colleagues to focus on Quality specific outcomes. **Schedule** **15/3 – Post Operative Neurological deficits** 6/4 – Renal Complications 19/5 – Post Operative Would Infection 17/6 – Return to theatre (bleeding)

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2.5	Post-operative Dialysis	Clinical review of PATS data undertaken for each patient to establish: • Risk score • Pre-Operative risk • Post-Operative risk	Understanding of where improvements can be made	M Ramsey, Unit Medical Director	01.10.21	Data extracted and shared with UMD w/c 02/08 Immediate actions taken to provide assurance on safety are:	
		• Action plan to be developed in response to findings	• Set goals for improvement upper quartile peer	A Zaidi, Clinical Director	30.11.21	○ Consultant only operating ○ Preop: patients at risk (pre-existing premorbid conditions) identified by surgeon and appropriate risk quoted + documented. **Completed**	
		• Delivery of action plan	• Deliver action plan for improvement	A Zaidi, Clinical Director	30.11.21		
		• Monitoring improvement	• Ensure improvement is sustainable	A Zaidi, Clinical Director	31.12.21	○ Intra-op: Full invasive monitoring, appropriate support of perfusion pressures on CPB and afterwards. The length of CPB and aortic cross	

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						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. **Completed** *Analysis of data undertaken by Dr Sameena Ahmed to review trend which will inform further discussions*	Meeting scheduled monthly with the Cardiac Surgeons & Anaesthetic colleagues to focus on Quality specific outcomes. **Schedule** 15/3 – Post Operative Neurological deficits

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						Completed	**6/4 – Renal Complications** 19/5 – Post Operative Would Infection 17/6 – Return to theatre (bleeding)
2.6	Use of Blood Products i) Identify the usage of blood products as highlighted by GIRFT	Record blood usage on PATS system	• Understand current performance and opportunities for improvement • Target upper quartile performance in peer group of 31 units • Ensure change is sustainable	M Ramsey, Unit Medical Director A Zaidi, Clinical Director	01.10.21 01.10.21	A request for utilisation of blood products has been made via Pathology; extraction from LIMS pathology system is currently underway. **Complete** Prospective method of capturing blood usage via the ICNAC database and will be displayed on the bespoke dashboard. **Complete** Mr Sharma is in the process of completing a 6 month audit on blood usage/ return to theatre	Process in place to ensure Consultants receive monthly data on blood usage for scrutinising and discussions Await outcome of audit to inform discussions at a later date

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						Analysis of data undertaken by Dr Sameena Ahmed to review trend which will inform further discussions	
	ii) Improve optimisation of patients pre and post operatively to improve blood produce usage and reduce LOS	• Benchmark against ***Plymouth Hospitals*** good practice & monitor improvement • Develop options for pre op IV iron clinic to improve quality, safety and clinical effectiveness	• Identify best practice that could be implemented locally • Provision of an IV iron clinic to improve clinical outcomes	D Packman, Directorate Manager L Jenvey, Senior Matron	20.08.21 30.09.21	SOP for 'Pre Op Bloods' to include when Hb threshold requires IV iron infusion pre operatively to reduce blood usage – Audit to be undertaken by PAC team Aug 21 – Jan 22 **Completed** Ensure all In house patients also receive Iron studies for effective pre operative work up **Completed.**	

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						Draft all Wales pathway implemented: Discussion held with Plymouth Hospital - referred on to Dr Mark Bennett who has confirmed same practices are followed at both hospitals, suggested that TEG system should be networked in theatre Blood usage data to be presented at monthly Audit meetings	
	Goal	**Method**	**Outcome**	**Lead**	**Timescale**	**Update**	
3.	**Processes & Patient Pathway**						
3.1	Day of Surgery Admission (DOSA) and Reduced Pre op Length of Stay (LOS)	• Benchmark against ***Blackpool Teaching Hospitals*** and upper quartile peer group for pre assessment, pre-admission and DOSA performance to enable improved DOSA levels	• Identify best practice that could be implemented locally • Standardised processes within the unit to achieve increase in DOSA; to 10% of elective	L Jenvey, Senior Matron L Jenvey, Senior Matron	01.9.21 SOP 6.8.21	Capacity Planning Meeting has been set up on a Mon and Thu (chaired by Senior Matron or Directorate Mgr.) to support improvement. **Completed**	Capacity Planning meeting continuing and identifying lost utilisation and opportunities for backfill etc

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		and improve pre-operative LOS • Develop action plan for pre- admission following benchmark review to include options, costs and benefits of dedicated pre-admission service w/ advanced nursing skills to assess and clerk patients and support access to anaesthetic reviews • Golden patient identified and listed 1st on priority list; 2nd patient to be DOS admission	admissions within 3 months and > to 20% within 6 months • Improved pre-operative LOS to upper quartile performance in peer group of 31 units • Minimise disruption and improve theatre utilisation	S Ahmed – Cons Anaesthetist A Zaidi, Clinical Director D Packman, Directorate Manager	Business Case 20.8.21 Business Case submitted Sept 21 09.08.21 01.02.2022	Working on plan to populate theatre lists 2-3 weeks in advance to support DOSA and reduced pre op LOS; need to work w/ theatres and anaesthetics to support. Pre operative Pathway **completed** DOSA Proforma completed and implemented. **Completed** Process agreed to make priority patient the golden patient. **Completed** Anaesthetic Resources to be identified to enable an effective Pre-assessment and pre-admission service – Clinic accommodation to be expanded to	As @ 18.2.22 – 10 DOSA admissions form the 1/9/21 – 18.2.22 As @ 18.2.22 – LOS post-operative data has shown that from September 2021 - 18.2.22 LOS 4 months was equal to or below the benchmark of 7.8 however 1 month was 7.85 and 1 month (November) 11.14 Awaiting outcome of Job planning discussions and Anaesthetic session allocation via Clinical Support Services

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						provide a daily DOSA service. Meeting held on 18.1.22 – Decision awaited Initial discussions taken place to agree plan for using hotel accommodation for Cardiac Surgery patients to stay overnight pre op to support DOSA. **Completed** Benchmark against ***Blackpool Teaching Hospitals*** for pre assessment, pre-admission and DOSA **Completed**	No patients have as yet been identified as requiring hotel accommodation
3.2	Discharge Processes	• Benchmark against ***Basildon and Thurrock University Hospital, Barts Health*** and upper quartile peer group for post op length of stay (LOS) to support	• Identify best practice that could be implemented locally • Reduced post op LOS stay to upper quartile performance in peer group of 31 units	L Jenvey, Senior Matron	01.09.21	AZ 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	

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		improvement in post op LOS • Development of patient admission and discharge SOP following benchmark review to include: ○ ERAS pathways ○ Weekend discharge plans ○ Role of daily senior decision maker ○ Options for nurse led discharge ○ Role of board rounds in effective discharge planning ○ Utilisation of Estimated Date Discharge	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 and Directorate/Service Group governance processes	L Jenvey, Senior Matron L Jenvey, Senior Matron A Zaidi, Clinical Director	15.09.21 30.09.21 Oct 21 onwards	support post removal echo on the weekend. **Completed** Re-issue the SOP for post op care of cardiac surgery patients. Safer discharge bundle. **Complete** Benchmark with other units regarding ERAS pathways. Consider updated processes and practice eg. Update patient information leaflets to improve LOS and wound care. Ensure weekend plans are fully worked up and discussed in Fri Board Rounds. DP to discuss with AZ	
3.3	Critical Care LOS Note: currently the unit has 12 CITU beds (10 L3 & 2 x L2) and not 20 identified in the GIRFT review.	• Review utilisation of Critical Care capacity to ensure appropriate step-down into lower level beds	• Target of no patients discharged home from a designated critical care bed	L Jenvey, Senior Matron	31.8.21	Utilisation and availability of beds on Dan Danino and Cyril Evans being monitored **Completed**	Amber patients are delayed in discharge from CITU due to the lack of Amber bed facilities within Cyril Evans Ward – improvement in Cardiac flow would Improve Critical care LOS. Discussions

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	(6 beds CHDU L2 Care, a further 2 CHDU beds unfunded = 8). CITU is also used to support "green" pathway for non-cardiac elective surgery (PACU)	• Ensure medical documentation completed when patients are deemed Medically fit to leave Critical Care Area	• Laptop to be purchased to ensure timely/accurate data entry	M Petty, Service Manager Dean Packman/Louise Jenvey	01.10.21 1.06.22	Daily Cardiac Safety Huddle has been established (chaired by Senior Matron) to support appropriate allocation of beds. **Completed** Business case to be developed to secure funding for the 2 unfunded CHDU bed, ACCP and educational support for the area	ongoing in regards to whether ring fenced beds are required.
3.4	Ratio of Urgent: Elective cases	• Demand/capacity exercise to be undertaken for elective and IP work to facilitate meaningful planning • Benchmark against ***University Hospital Southampton Cardiology unit*** to understand their zero tolerance approach to cancellations	• 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 • Explore feasibility of pooling non-elective	D Packman, Directorate Manager D Packman, Directorate Manager	1.10.21 01.09.21 01.09.21	Capacity Planning Meeting has been set up on a Tue and Thu to support improvement. **Completed** Locum Consultant in post and undertaking additional theatres; job planned for 2x all day theatres p/wk but can increase from Sept. onwards once settled in. **Completed** Discussion to take place with Consultants	

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			cases ready for next available theatre and next available appropriate surgeon	A Zaidi, Clinical Director		at next quorate Consultant Meeting. **Completed** Southhampton and Blackpool contacted in regards to Benchmarking **Completed**	
3.5	Weekend Operating Lists	• Keep under review – not required currently – focus on delivering full available capacity during core hours	• Monitor requirements – If all core capacity is fully utilised and additional capacity is still required this will be reviewed	D Packman, Directorate Manager	31.08.21	NA	
3.6	Timeframe to get back to core pre COVID activity – Elective/Emergency Surgery	Identify constraints and work through solutions: • Bed capacity Pre/Post admission • Green/Amber Pathway theatre capacity • Staffing resources	• Pre-core activity re-established for 2019/20 on monthly rate • Activity increased to deliver WHSSC contracted activity	D Packman, Directorate Manager D Packman, Directorate Manager	28.02.22 01.10.21	Capacity meeting on Mon & Thu being used to closely monitor and maximise the amount of surgical activity; there are constraints w/ theatre scrub staff and anaesthetics that will become more problematic as capacity further increases.	

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	Goal	**Method**	**Outcome**	**Lead**	**Timescale**	**Update**	
4.	**Governance and Assurance**						
4.1	Clinical Outcomes Data	• 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-	• 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 forum • No surprises for the Senior Management and Executive team	P Kumar, Deputy Unit Medical Director F Bhatti, Consultant Cardiothoracic Surgeon A Zaidi, Clinical Director	01.10. 21 In line w/ dates of Audit and Board mtgs. In line w/ dates of Audit and Board mtgs.	Format of quality metrics report being worked through in advance of next M&M meeting on 14/09. Clinical dashboard under development – version 1 scrutinised by stakeholders. Go live date January TBC. MR to review and sign off 22/12. Final presentation to be delivered at Exec GIRFT meeting 17.1.21. RE to contact WHSSC colleagues to request sign off at the WHSSC meeting on the 1.2.22. WHSSC to meet with	Upload FB Presentation 14.2 De-escalated to Level 3 on 8/2/22

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		monthly Cardiac Surgical Board				Audit Lead Andrea to review dashboard data in March 2022 – Dashboard will then be shared with wider colleagues	
4.2	Reporting and Escalation Framework	• Publish outcome and improvements via Morriston Service Delivery Group's Quality & Safety Group	• Report to be completed and discussed in Morriston Service Delivery Group's Quality & Safety Group	A Zaidi, Clinical Director	15.09.21	F Bhatti, Consultant Surgeon & Audit Lead attending Morriston SG Q&S Group and providing updates on cardiac surgery outcomes as part of the governance report. Presentation to be delivered to Delivery Unit Q&S Group March 16th 2022.	
4.3	Development of Clinical Outcomes Dashboard	• 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	• 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	A Zaidi, Clinical Director P Kumar, Deputy Unit Medical Director	23.7.21 31.12.21	Clinical dashboard under development – version 1 scrutinised by stakeholders. Go live date January TBC. MR to review and sign off 22/12. Final presentation to be delivered at Exec GIRFT meeting 17.1.21. RE to contact WHSSC colleagues to request sign off at the WHSSC meeting on the 1.2.22	

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			report quality measures				
4.4	Data Submissions to NICOR	• Review current process for submitting data via clinical team and clinical audit coordinator to ensure sufficient capacity in place • Review of audit coordinator provision to assess if current resource is sufficient	• Unified approach and clinical consensus/educational requirements addressed • Resource requirement to cover the current single handed audit coordinator to be identified	A Zaidi, Clinical Director D Packman, Directorate Manager	06.8.21 31.08.21	A workload review for the audit coordinator has begun and will run for a 1 month period during August. **Complete** GH & LJ. Review to be undertaken of clinical staff unable to be patient facing to identif**y r**esources to support	
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)	• 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	• Ownership of outcomes (morbidity as well as mortality) by clinicians • Develop culture of constant improvement	A Zaidi, Clinical Director M Ramsey, Unit Medical Director	01.09.21 01.09.21	Weekly Triumvirate (CD. DM & SM) Meeting established to provide operational oversight of the implementation of the GIRFT Gold Action Plan. **Complete** Format of quality metrics report being	

		actions being taken within directorate		P Kumar, Deputy Unit Medical Director	31.12.21	worked through in advance of next M&M meeting on 14/09. F Bhatti (Audit Lead) attending Morriston SG Q&S Group and providing updates on cardiac surgery outcomes as part of the governance report. Clinical dashboard under development – version 1 scrutinised by stakeholders. Go live date January TBC. MR to review and sign off 22/12. Final presentation to be delivered at Exec GIRFT meeting 17.1.21. RE to contact WHSSC colleagues to request sign off at the WHSSC meeting on the 1.2.22	