Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Reference Number: FOI202223/410
From: Private Individual

Date: 20 January 2023

Subject: Royal College of Surgeons Report from September 2022

Under Freedom of Information Act, I would like to request the following information:

Q1 Royal College of Surgeons Report from September 2022, which was made available to the trust in December/January 2023 into cardiac / thoracic / cardiothoracic surgery at the trust.

A1 With regards to copies of written material/original documents, the Freedom of Information Act gives rights of public access to information held by public authorities. This right covers all recorded information held by a public authority; public authorities only have to provide information they already have in recorded form, they do not have to create new information or respond to general questions and the Act doesn't confer any explicit right to copies of original documents.

In this case we have reviewed the requested document and, on this occasion have taken the decision to release the contents of the report. Please see attachment *Response FOI202223 410*.

Appendix A of the report has been redacted as it is exempted under Section 41(1) – Information provided in confidence. This information was obtained by the Trust from another organisation and, the disclosure of the information would constitute a breach of confidence actionable by that organisation or any other person.

Appendix B of the report has been redacted as it is exempted under Section 40: Personal data. Providing this information would likely identify individuals involved.

Clinical Record Review Report

Royal College of Surgeons of England
ADVANCING SURGICAL CARE

Report on 13 clinical records relating to cardiothoracic surgery on behalf of Liverpool Heart and Chest Hospital NHS Foundation Trust

Report issued: 19 December 2022

A clinical record review on behalf of:

The Royal College of Surgeons of England

The Society for Cardiothoracic Surgery in Great Britain and Ireland

Review team:

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1. Introduction and background

On 12 November 2021, Dr Raphael Perry, Medical Director for Liverpool Heart and Chest Hospital NHS Foundation Trust ('the Trust'), wrote to the Chair of the Invited Review Mechanism (IRM) to request an invited clinical record review of 13 cardiothoracic surgery cases.

In particular, the request highlighted concerns relating, but not limited to:

- Clinical decision making and management of patients undergoing cardiothoracic surgery some of whom had subsequently died;
- Lack of cover for consultants on leave and no formal handover process;
- Missing information on patients' death certificates;
- Cremation forms being signed without adhering to due process;
- Failures in communication with patients and their families;
- Failures in documenting care within patient records;
- Problematic relationships between members of staff; and
- Apparently higher than risk adjusted death rates in cardiothoracic surgery.

These concerns led to a number of cases of patient care being reported under a Freedom to Speak Up disclosure, as well as being anonymously reported to the Care Quality Commission (CQC). The Trust conducted an internal investigation, after which the invited review request was made. The request highlighted that the review team should assess the: quality and safety of surgical care, theatre safety practices, behaviours and team working, multi-disciplinary team (MDT) work, communication with patients and clinical governance.

This request was considered by the Chair of the Royal College of Surgeons of England (the RCS England) IRM and a representative of The Society for Cardiothoracic Surgery in Great Britain and Ireland, and it was agreed that an invited clinical record review would take place, with a specific focus on the cardiothoracic surgical service.

A review team was appointed and an invited review of the cases was arranged. There were logistical difficulties in arranging remote access for the review team to the Trust's electronic patient record system. As a result, the review team attended the Trust on 26 September 2022 to review the clinical records for the 13 cases.

The review team considered the care provided to the 13 patients put forward by the Trust. This included the review of the clinical records, medical imaging and reports, and information put forward regarding the complaints and concerns raised and how they were internally investigated and dealt with by the Trust. The review team did not have access to medical records (including minutes of MDT meetings) that were held in other hospitals.

The appendices to this report list the members of the review team. This clinical record review was carried out with the purpose of meeting the terms of reference outlined in section two, and drew conclusions from the information provided in relation to the clinical record review only.

The notes made by the clinical reviewers with regard to the individual cases are detailed in Appendix A. These represent their initial views on each case while looking at them individually and do not necessarily reflect their final conclusions. The review team conclusions are based on the information provided to them, which are outlined in section three. The conclusions section of this report contains the review team's views on the care provided to these patients, and recommendations based on these conclusions are outlined in section four.

2. Terms of reference for the review

The following terms of reference were agreed between the RCS England and the Trust, prior to the review bring undertaken.

Review of cardiothoracic clinical records at Liverpool Heart and Chest Hospital NHS Foundation Trust (the Trust) under the Invited Review Mechanism.

Background

This invited review has been commissioned by the Trust following a number of concerns being raised under a Freedom to Speak Up (FTSU) disclosure to NHS England and Improvement (NHS E&I). The Trust was notified of this disclosure by NHS E&I in May 2021.

As well as the FTSU disclosure being made, specific cases of patient care were reported anonymously to the Care Quality Commission (CQC). As a result, the Trust performed its own internal investigation, which involved having discussions with staff and reviewing clinical records. Following the conclusion of the internal investigation, at the request of the CQC, the Trust provided it with a copy of the investigation report.

The Trust considered that, following the concerns being raised and the conclusion of its own internal investigation, the issues raised were complex and required specialist expertise through an independent and objective framework. The Trust therefore invited a clinical review of the standard of care provided to patients within its cardiothoracic surgical service. The review team will assess a sample of 13 clinical records provided by the Trust, and make specific findings and recommendations. This will identify whether there are specific areas of concern with regard to the standard, safety and quality of surgical care being provided within the cardiothoracic service.

Review

The review will involve:

- A clinical record review of 13 specific cases put forward by the Trust.
- Optional - interviews with the consultant surgeons and other relevant clinical staff responsible for the care of the patients.

Terms of Reference

In conducting the review, the review team will consider the quality, safety and standard of surgical care provided in the cardiothoracic service, as demonstrated within the 13 clinical records provided by the Trust, with specific reference to:

1. Assessment including taking of history, examination and diagnosis.
2. Investigations and imaging undertaken.
3. Treatment including clinical decision-making, case-selection, operation and/or procedures, including whether there was any information to suggest that patients were not receiving the correct treatment.
4. Obtaining consent from patients and, communication with patients, their families, their GP and/or other relevant healthcare professionals.
5. Behaviours, communication and team working, with specific reference to the operation of the multi-disciplinary team (MDT), and its effectiveness.
6. Record keeping, including whether there was any information to suggest that information documented was incorrect and/or misleading.

7. Clinical governance.

Conclusions and recommendations

The review team will, where appropriate:

- Form conclusions as to the standard and quality of care provided to patients within the cardiothoracic surgical service and establish whether there is a basis for concern in light of the findings of the review.
- Identify examples of best practice within the service.
- Make recommendations for the consideration of the Medical Director of the Trust as to courses of action which may be taken to address any specific areas of concern which have been identified and/or to otherwise improve patient care within the cardiothoracic service.

The above terms of reference were agreed by the College, the healthcare organisation and the review team on 25 April 2022.

3. Conclusions

The following conclusions are based on the information provided to the review team from the clinical records reviewed and any other supplementary information provided.

Overall, the review team found that the standard of care provided to patients in all cases was appropriate, and did not identify any concerns with respect to the treatment that these patients received. Full details regarding each of the cases considered by the review team can be found in Appendix A.

3.1. Assessment, including taking of history, examination and diagnosis

In the majority[1] of cases reviewed, the review team considered that patients received an appropriate standard of assessment.

However, there were two cases where the assessment process left room for improvement:

In case **A8**, where the patient was treated for a mass in the left upper lobe, the review team were unable to locate entries within the patient's records arguing for a more timely approach following transfusion and consideration of a course of antibiotics. Whilst the patient was admitted with moderately severe anaemia, and a raised white blood cell count, an explanation for these abnormalities was not evident. The review team considered that the patient should have been investigated further, using the opportunity to make the patient fit for surgery.

In case **A9**, where the patient had lung cancer, having regard to the large size of the patient's tumour (10cm) and that the staging was at least 2B or 3A[2], the review team considered that the patient should have had a CT[3] or MRI[4] scan taken of the head.

3.2. Investigations and imaging undertaken

In the majority[5] of cases reviewed, the review team considered that acceptable investigations and imaging, and where appropriate, staging were taken in order to guide the treatment that the patients received.

However, this was with the exception of case **A9**. The review team considered that there could have been room for improvement by taking a CT or MRI scan of the patient's head, as indicated in paragraph 3.1, given the size and staging of the patient's tumour.

3.3. Treatment, including clinical decision making, case selection, operation or procedures

In all of the cases reviewed the review team considered that there was an appropriate standard of clinical decision making and that patients received acceptable treatment. This included providing excellent peri-operative and post-operative care, including in a number of cases where complications and unforeseen events arose following surgical procedures. The review team

[1] A1, A2, A3, A4, A5, A6, A7, A10, A11, A12 and A13.
[2] NHS cancer staging system: https://www.nhs.uk/common-health-questions/operations-tests-and-procedures/what-do-cancer-stages-and-grades-mean/ and NHS lung cancer staging system: https://www.nhs.uk/conditions/lung-cancer/diagnosis/
[3] Computerised tomography scan.
[4] Magnetic resonance imaging scan.
[5] A1, A2, A3, A4, A5, A6, A7, A8, A10, A11, A12 and A13.

noted that, in a number of cases[6], the patients sadly died. They noted that concerns had been raised that patients had been receiving the incorrect treatment. However, from their assessment of the clinical records, the review team were unable to identify any information to suggest that patients had received incorrect treatment.

3.4. Obtaining consent from patients and communication with patients, their families and/or their GP

In all of the cases reviewed, the review team considered that there was a good standard of obtaining consent from patients, as well as communication with the patients, their families, their GP and other relevant healthcare professionals.

3.5. Behaviours, communication and team working

In all of the cases reviewed, with the exception of one[7]; the review team considered that there was an appropriate standard of team and MDT working including communication amongst professionals within teams and between teams. There was no suggestion of any behaviours of concern. However, this was with the caveat that in some cases the review team did not have access to MDT meeting minutes that were held in other hospitals. Furthermore, the review team considered that it would not be easy to identify communication issues between clinicians, or any behaviours of concern, from a review of clinical records alone. The review team considered whether interviewing staff at the Trust would be of benefit, but decided on balance that this was not required, as they were able to build up a holistic picture of team and MDT working, communication and behaviours from their review of the records. The review team did not consider that staff would be able to comment further on this aspect of care in relation to the individual cases.

In case **A8**, the review team considered that there was room for improvement in respect of team working and communication. They considered that, given how unwell the patient was, the anaesthetist should have raised with the operating surgeon that she may have not been fit for surgery, until further evaluation took place.

3.6. Record keeping

In all of the cases considered, the review team found the clinical records to be clear, accurate and legible. The review team noted that concerns had been raised that information documented within patient records was incorrect or misleading. The review team were unable to identify any information to suggest that record keeping was incorrect or misleading, including in two cases[8] where concerns had been raised regarding misleading death certificates.

3.7. Clinical governance

The review team considered that the clinical governance processes were acceptable in all of the cases reviewed. This included appropriate referral of cases[9] to the Coroner's Office, where patients had sadly died. In two[10] of the cases reviewed, the review team did not consider that any clinical governance issues arose.

However, the review team considered that the clinical governance process could be improved by ensuring that a surgeon was leading these processes, with dedicated time in their job plan to fulfil this role and ensuring there were minutes of mortality and morbidity (M&M) meetings.

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[6] A1, A2, A3, A4, A6, A7, A8, A10, A12, A13.
[7] A8.
[8] A2 and A3.
[9] A1, A2, A3, A6, A7, A8, A10 and A12.
[10] A9 and A11.

3.8. Best practice

The review team identified the following examples of best practice within the service:

In case **A1**, the patient sadly died in the post-operative period following a right upper lobectomy for lung cancer. The review team considered that appropriate clinical governance took place, with the patient being referred to the Coroner's Office, and discussion regarding a post-examination being undertaken, which confirmed that the cause of death was a pulmonary embolism. The review team considered this to be best practice, which demonstrated a willingness to engage in governance.

In case **A5**, the patient was treated for a lesion in the right lower lobe. The review team considered that the patient was appropriately assessed for surgery, with an up to date performance status assessment, and a bronchoscopy and mediastinoscopy, to surgically stage the tumour. The review team considered this to be best practice.

In case **A10**, the patient sadly died of pneumonia and operated lung cancer. The review team noted that a letter of condolence was sent to the patient's family following their bereavement. The review team considered this to be an example of best practice, with regard to communication with patients' families.

The review team also found that, in all cases reviewed, the clinical notes were accurate, clear, complete and contemporaneous. In cases where the notes were handwritten they were legible. The review team considered this to be another example of best practice.

4. Recommendations

4.1. 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 establish whether the patient in case **A9** has received appropriate clinical follow-up, given that it is unclear whether this had continued beyond September 2018 from the review team's assessment of the patient's records.

2. The Trust should be using the Medical Examiner/Structured Judgement Review process for deaths that occur within the unit, and this should be confirmed.

4.2. Recommendations for improvement

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

3. The Trust should develop a policy or protocol give clear guidance on when CT or MRI scans of the head should be taken, as part of pre-operative assessment and investigations for lung cancer. This should be in accordance with the National Institute for Health and Care Excellence (NICE) guidelines for lung cancer: diagnosis and management, 28 March 2019 (NG122)[11].

4. The Trust should ensure there are minutes taken of M&M meetings, and a copy of the relevant entry for each patient is included within the patient records. A dedicated consultant surgeon should lead such clinical governance processes, and should have allocated time in their job plan to fulfil this role.

[11] https://www.nice.org.uk/guidance/ng122/resources/lung-cancer-diagnosis-and-management-pdf-66141655525573

5. Guidance for the healthcare organisation

5.1. 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 in Great Britain and Ireland 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.[12]

5.2. Further contact with the Royal College of Surgeons of England

Where recommendations have been made that relate to patient safety issues, the Royal College of Surgeons of England will follow up with the healthcare organisation to request confirmation that timely action has been taken to address these recommendations.

If further support is required the College may be able to facilitate this. Additionally, if it is considered that a further review would help to assess improvements that have been made the College's Invited Review service may be able to undertake this.

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