Independent External Mortality Review

Terms of Reference

Cardiac Surgical Services

St George's University Hospitals NHS Foundation Trust

November 2018

Version Control

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Version	**Author**	**Date**	**Changes**
0.1	Cathy Cale	13-09-2018	First draft
0.2	Cathy Cale	14-09-2018	Governance arrangements updated
0.3	Cathy Cale	17-09-2018	Process points updated following discussion with Trust
0.4	Cathy Cale	21-09-2018	Minor updates following comments from Kathy McLean and Steering Group (20-09-18)
0.5	Cathy Cale	24-09-2018	Updated following feedback from NHSI Patient Safety Team
0.6	Cathy Cale	25-09-2018	Updated to ensure the primary focus is the “NICOR” cohort and the secondary foci are samples of discharge to 30 days and waiting patients
0.7	Cathy Cale	05-11-2018	Governance section updated and legal comments received. Programme support removed as superseded by contract of engagement
0.8	Stephen Picken	23-11-2018	Added appendix B outlining rationale and assessment regarding mechanism and approach for informing families / next of kin.
0.9	Cathy Cale	27-11-2018	Appendix B figure 2 added
Final	Cathy Cale	30-11-2018	Agreed by Steering Group as Final

1. Background

a. St George's University Hospitals NHS Foundation Trust (the "Trust") provides a comprehensive, sub-regional cardiothoracic service, including support to the Heart Attack Centre and major trauma centre. Cardiac surgery outcomes are reported by Trusts to the National Institute for Cardiovascular outcomes (NICOR) who analyse and report the data nationally.
b. The Trust has received two alerts from the National Institute for Cardiovascular outcomes (NICOR) for the period April 2013 - March 2016, and 2014-2017. An 'alert' is when survival falls below a line 2 standard deviations below the mean for the peer referenced group of 31 cardiac surgery units in the UK.
c. After the first alert, the Trust undertook an internal review of deaths in that time period. The Trust developed an action plan based on the results of that review. After the second alert, the Trust commissioned an external review of the service (not a case note review of individual patients) by Dr Mike Bewick, which was published in August 2018.
d. Following this report, there has been significant media attention regarding the service.
e. The Trust is engaged in discussions with HM Coroner to ensure that she has been appropriately notified of deaths where concerns have been raised by internal Trust review processes.
f. NHS Improvement[1] is responsible for monitoring and supporting NHS foundation trusts (FTs) through its provider licence[2]. NHS Improvement supports FTs to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.
g. NHS Improvement has decided to commission an external review of mortality of the cardiac surgery patients that died during the period to which the alerts relate. This is to verify that the Trust has identified any lessons to be learnt from the deaths. If further action is required, NHS Improvement will support the Trust through business as usual mechanisms.
h. To avoid duplication, the outputs from this review will be used to inform the Trust's discussion with HM Coroner regarding deaths covered in the review period.

[1] Relying upon the powers of Monitor
[2] See Chapter 3 of Part 3 of the Health and Social Care Act 2012

2. Scope

a. The time period of the review will be deaths since the first NICOR alert (01-04-13) until 01-09-18.
b. “Cardiac surgery” is defined as any surgical procedure undertaken by a cardiac surgeon. It does not include procedures undertaken by interventional cardiologists/radiologists
c. A strengthened Trust mortality review process is in place to review deaths after 01-09-18, any deaths after this date are outside the scope of this review.
d. The primary scope will be deaths of patients after cardiac surgery.
e. “After surgery” has been defined for the purpose of this review as in hospital deaths during initial the cardiac surgical episode
f. Two areas of secondary scope will be reviewed.
g. For these patients, a recent cohort (6 months 01-03-18 to 31-08-18) will be reviewed initially. The review will be extended by the panel if they identify significant areas of concern.
h. These 2 secondary scope cohorts will be
i. deaths within 30 days of discharge ii. patients who have died whilst waiting for cardiac surgery.
i. “Waiting for surgery” has been defined as patients who have been identified during an inpatient admission as requiring surgery and who have died before surgery is undertaken
j. In addition, any other deaths of patients under the care of the St George’s cardiac surgery service in this time period (01-04-13 to 01-09 -8) where family or others have raised concerns will be reviewed.

3. Scale and Timescale

a. It is estimated that the review will cover in the region of 200- 250 patients
b. A significant proportion of these will have already been subject to a case note review (structured judgement review), Significant Incident investigations or local mortality reviews
c. A large proportion will also have been discussed with the coroner, with a smaller proportion having had inquests
d. Estimates of the time taken for review is difficult as different cases will take significantly different amounts of time to review
e. We estimate a reviewer can review 4 cases per day in a panel setting
f. 40-person days are therefore estimated as required to complete the review

g. Time frame within which this can be completed will depend on reviewer availability and numbers
h. It is estimated that a comprehensive review will take at least 6 months to complete
i. Provisional timescales will be agreed with the Chair of the mortality review panel in advance of the process commencing, and will be finalised once the first panel meeting has occurred

4. Project Resource

a. The Trust will commission an external supplier to provide project management and administrative support for the review
b. The Trust lead for Mortality and staff from the risk and governance team will be allocated time to support the review process
c. A panel of external reviewers will be commissioned by NHSI

5. Governance

a. The Panel will provide an interim progress report after each of their meetings. The report will include:
    i. Number of cases reviewed and % progress towards completion ii. Number of cases where concerns raised
    iii. Number of cases where review agrees/ significantly disagrees with previous Trust reviews in terms of likelihood that problems in care contributed to the patient's death
    iv. Lessons learned and themes
    v. Any immediate actions the Trust is required to take including recommendations to undertake an SI or refer to the coroner
b. The project progress report will be
    i. Provided to the Trust (via the Medical Director or his nominated representative) for information, action and discussion (as required) at their Mortality Monitoring Group and Trust Executive Committee. The Trust will ensure that relevant information from the panel progress report follows the normal governance routes via the Quality and Safety Committee to Trust Board. ii. Provided to the NHSI/E SGH steering group (via the programme lead)
c. If required, the Trust will develop actions in response to the progress report (including SIs initiated and cases referred to the coroner and outcome thereof) and will:
    i. Submit the report and actions to the Independent Scrutiny Panel for agreement of actions
    ii. Submit the report and actions to the NHSI/E SGH steering group

(via the programme lead) for assurance iii. Submit to the Clinical Quality Review Group for information

d. Each group receiving the report will provide any feedback or any additional questions they would like addressing to the Panel Chair (via the project secretariat) and NHSI/E (Programme Lead)
e. A final report will be completed by the review panel chair within 2 weeks of completion of the last case note review
    i. The final report will be submitted to the Trust and provided to NHSI/E Programme Lead for information ii. The Trust will develop an action plan within 2 weeks and submit this for scrutiny to the Independent oversight panel
    iii. Once the action plan is approved, the report and action plan will be submitted to NHSI/E Programme lead
    iv. Ongoing assurance will be via CQRG

6. Review Panel

a. The independent review will be undertaken by a review team of independent external reviewers. The review team will consist of a minimum of 2 cardiac surgeons, 2 cardiologists and a cardiac anaesthetist and will have a nominated chair (cardiac surgeon/cardiologist).

7. Review Process and Principles

a. The review panel will be provided with a methodology, process (Appendix A) and direction (see section 9) in relation to the conduct of the review to ensure that there is consistency in approach in reviewing each case.
b. The panel will give due consideration to the application of relevant policies and procedures that were in place both nationally and locally at the time of the patient's care
c. The methodology used will be a modified structured judgement review
d. The reviewers will use a combination of original medical records and Trust previous reviews to review cases.
e. If the review team identifies any material concerns that need further immediate investigation or review, they will notify the trust medical director/ the NHS I/E regional medical director with immediate effect.
f. The review team will use the following key principles
    i. Engage wisely, openly and transparently with all relevant parties participating in the review process
    ii. Be respectful when dealing with individuals who have been impacted by the events being investigated

iii. Adopt an evidence-based approach
iv. Apply the principles of a Just Culture whenever considering the roles of individual members of staff

8. Directions to the review team in relation to the conduct of the review

a. Were there any gaps in the records provided that impeded completion of reviews or raised concerns regarding completeness of record keeping/ data submission.
b. Were the standards of care provided to patients in line with national and local policies and standards
c. Was there evidence of care that fell below expected standards of care
d. Were there problems in care that may have or definitely contributed to the death of the patient

Appendix A – Process Outline