Trust reviews historic cases

We have written to families who raised concerns and queries about their care in our maternity service going back some 19 years. These concerns were raised following the announcement last year that the Secretary of State for Health had asked NHS Improvement (NHSI) to undertake an independent review.

The independent review is looking at historic investigations into a number of cases which relate to newborn, infant and maternal deaths raised in a family's letter to the Secretary of State for Health in December 2016.

The announcement of this investigation in April 2017, led to 16 families coming forward with questions about their care, and an additional 24 cases were put forward for review by the independent midwife leading the NHSI review. These cases cover a 19-year period. During this period, we have seen over 91,000 babies born at SaTH.

We established a Clinical Review Group to examine those cases which were not included in the Secretary of State's review to ensure a robust process and complete transparency. The Group undertook a preliminary review of those cases where there had already been a complaint or serious incident and assessed the clinical care of the remaining patients using a structured process adapted from the Royal College of Physicians. This tool helped to identify if there was any potential learning from the care provided at the time.

The Group consisted of clinical leaders from neonatology, obstetrics, paediatrics and midwifery and to ensure openness, transparency and for further assurance representatives from Telford and Wrekin, and Shropshire Clinical Commissioning Groups. The clinicians involved in the review process were not involved in the original care that those families received.

Of the 40 cases, five cases were unidentifiable from the information provided so no further action could be taken, and of the 35 identifiable cases which date from 1998; we have:

- Written to 19 families to say there were no signs of any failures in care and offered to discuss the case further with the family should they wish.
- Written to four families to say there is potential for further learning and to seek permission for the case to be reviewed by independent clinical experts to ensure all of the learning is established.
- Written to eight families recognising a review had been undertaken previously and, on that basis, it was recommended these cases undergo further examination and to seek permission for the case to be reviewed by independent clinical experts.

The cases of four families were reviewed and there were no signs of any failures in care. These families were unaware their cases had been put forward for review by the independent midwife leading the NHS Improvement review and we will not contact them individually. The Clinical Review Group recommended this approach which was supported by the Trust Board as it was felt contacting these families after such a length of time and potential changes to family circumstances may cause these families further grief or anguish.

Over the coming weeks, we will liaise with the families we have written to and for cases where we have received permission we expect to review the associated independent expert reports this winter.

We are determined to approach all such cases in an open, transparent way and to learn from these reviews. We are committed to making improvements rapidly and will share our learning from these cases later this year.

FREQUENTLY ASKED QUESTIONS

Q. How were additional cases identified for the Trust to review?

As part of the NHS Improvement investigation the independent midwife leading the review identified 24 additional historic maternity cases and asked the Trust to examine them further. Also 16 families came forward as a result of the media coverage when the NHS Improvement review was announced.

Q. Who was part of the Trust's Clinical Review Group?

The Group consisted of clinical leaders from neonatology, obstetrics, paediatrics and midwifery; and to ensure openness, transparency and further assurance, representatives from Telford and Wrekin, and Shropshire clinical commissioning groups. The clinicians involved in the review process were not involved in the original care that those families received.

Q. Are the cases all recent?

No. The cases range from 1998 to 2017, over a 19 year period.

Q. My case has not been recommended for further review by independent clinical experts what else can I do?

We would encourage these families to contact the Women and Children's Care Group Director at the Trust via **sath.womenandchildren@nhs.net** or 01952 – 641222 Extension: 5994 to arrange a time to discuss their case further so we can ensure all of their concerns have been addressed and that we learn as much as we can to improve the services we provide.

Q. Who are the independent clinical experts that will be conducting the external reviews?

The clinicians undertaking the reviews consist of clinical leaders from neonatology, obstetrics, paediatrics (where relevant) and midwifery from across the country.

Q. How long will it take for these reviews to be completed?

It is expected that all cases (where consent has been given) will have been reviewed by winter 2018 and families will be contacted individually at this time.

Q. Will the families have an opportunity, should they wish to, to talk through their concerns with the Clinical Review Group or the independent clinical experts?

Families will have the opportunity to talk about their case and any further concerns with the Women and Children's Care Group Director. This can be arranged via emailing **sath.womenandchildren@nhs.net** or 01952 – 641222 Extension: 5994

Q. Will the learning from these reviews be shared?

Yes. We are determined to approach all such cases in an open, transparent way and to learn from these reviews. We are committed to making improvements rapidly and will share our learning from these cases when the reviews have been completed later this winter.

Q. Should women who are planning to give birth at the Trust be worried about the quality of care they will receive?

No. We know the subject of our maternity service is an emotive one however the safety of women and babies using our maternity service continues to be our number one priority. We are committed to drawing all possible learning from the historic cases to establish safer practice.

Q. Will this have any impact on the clinical commissioning groups' plan to consult on how maternity services are delivered across the county?

No, this has no impact on the future model of care that is being proposed by Shropshire, and Telford and Wrekin clinical commissioning groups which will be subject to public consultation in due course.