The Shrewsbury and Telford Hospital NHS Trust

Paper 14

Reporting to:	**Trust Board - July 2018**
Title	Update of Legacy Case Review
Sponsoring Director	Deirdre Fowler – Director of Nursing, Midwifery & Quality.
Author(s)	Jo Banks (Women & Children's Care Group Director)
Previously considered by	Quality & Safety Committee, Executives and CQRM.
Executive Summary	The Quality & Safety Committee and Trust Board have received a number of updates relating to the progress of work of the Legacy Resolution Group. The group commenced to provide oversight and assurance that the Trust takes appropriate action in relation to questions raised within a number of cases that have been brought to the Trusts attention; as a result of the Secretary of State (SoS) review of maternity services. The purpose of this paper is to update the Trust Board on current progress and describes the current position and next steps in relation to the Legacy cases.
Strategic Priorities 1. Quality and Safety	☒ **Reduce harm, deliver best clinical outcomes and improve patient experience.** ☒ **Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards** ☐ Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme ☒ **To undertake a review of all current services at specialty level to inform future service and business decisions** ☐ Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme
2. People	☐ Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work
3. Innovation	☒ Support service transformation and increased productivity through technology and continuous improvement strategies
4 Community and Partnership	☐ Develop the principle of 'agency' in our community to support a prevention agenda and improve the health and well-being of the population ☐ Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies
5 Financial Strength: Sustainable Future	☐ Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme
Board Assurance Framework (BAF) Risks	☒ If we do not deliver **safe care** then patients may suffer avoidable harm and poor clinical outcomes and experience ☐ If we do not work with our partners to reduce the number of patients on the **Delayed Transfer of Care** (DTOC) lists, and streamline our internal processes we will not improve our 'simple' discharges. ☐ Risk to **sustainability** of clinical services due to potential shortages of key clinical staff ☐ If we do not achieve safe and efficient **patient flow** and improve our processes and capacity and demand planning then we will fail the national quality and performance standards ☐ If we do not get good levels of **staff engagement** to get a culture of continuous improvement then staff morale and patient outcomes may not improve

	☐ If we do not have a clear **clinical service vision** then we may not deliver the best services to patients ☐ If we are unable to resolve our (historic) shortfall in **liquidity** and the structural imbalance in the Trust's **Income & Expenditure** position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment
Care Quality Commission (CQC) Domains	☒ Safe ☒ Effective ☒ Caring ☐ Responsive ☐ Well led
☐**Receive** ☒ **Review** ☒ **Note** ☒ **Approve**	**Recommendation** **The Trust Board are asked to note and approve the approach outlined within the report.**

Situation

Following a clinical review process involving legacy cases identified during 2017; the care group contacted **31** families on the 4th June 2018 following a one week delay to enable stakeholders to prepare communication statements. The process of communication with families and stakeholders has been supported by a proactive media and communications plan.

Background

In April 2017, the Secretary of State for Health asked NHS Improvement to undertake an independent review of historic investigations into a number of cases which relate to new-born, infant and maternal deaths (subject to family consent) at the Trust following concerns being raised by a family in a letter to him in December 2016. The announcement of this investigation in the media led to the Trust being made aware of families who had concerns and queries about their care over a number of years.

Assessment

The following progress update is accurate as of **21st June 2018** relating to the **31** letters sent:

3 letters have been returned; reported that the addressee no longer lives at the address; despite checking with the relevant General Practice and NHS England.

The care group wrote to **12** families to say there were potential signs of omissions of care and to seek permission for the case to be reviewed by independent clinical experts. Of the **12** families contacted; **9** have responded (to date) to provide consent for external review. It is estimated that once consent is received, the external review process will take up to 6 months; depending on the complexity of the issues concerned.

The care group wrote to **19** families to say there were no signs of care delivery omissions, and offered to discuss the case further with the family. Of the **19** families contacted; **3** have responded to discuss the review process with the care group director. Two of the 3 families will be meeting the Head of Midwifery and/or the Clinical Director for Obstetrics to discuss the review process and the care they received. One family has currently not responded to initial contact from the care group director.

Following the media and communication disseminated regarding the legacy case review; a further 4 families have contacted the care group (outside the legacy review) enquiring about their previous care in. The care group director is meeting all the families to understand their concerns.

In summary, a total of **12** of the 31 families have contacted the care group in response to the letter received.

Recommendations

The Trust Board is asked to note and approve the update of the legacy case review.