NHS
The Shrewsbury and Telford Hospital
NHS Trust

Paper 10

Recommendation ☑ **DECISION** ☑ **NOTE**	The Trust Board is asked to note and discuss the update of Legacy Case Review
Reporting to:	**Trust Board**
Date	27 September 2018
Paper Title	Update of Legacy Case Review
Brief Description	The 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 regarding questions relating to a number of cases that have been brought to the Trusts attention; both as a result of the Secretary of State (SoS) review of maternity services and also media coverage. Following the legacy paper discussed publicly at the Trust Board in June 2018; further families came forward with questions regarding the review process and also questions relating to their care. This was repeated following the media coverage in August 2018; whereby further families came forward. The purpose of this paper is to update the Board on progress and describes the current position in relation to the legacy cases and also those families who have subsequently contacted the Trust following media coverage.
Sponsoring Director	Deirdre Fowler, Director of Nursing, Midwifery and Quality
Author(s)	Jo Banks, Care Group Director, Women's & Children
Recommended / escalated by	None
Previously considered by	**None**
Link to strategic objectives	**Patient and Family** – through partnership working we will deliver operational performance objectives **Safest and Kindest –** delivering the safest and highest quality care causing zero harm
Link to Board Assurance Framework	RR1204
Equality Impact Assessment	◉ **Stage 1 only (no negative impacts identified)** ○ **Stage 2 recommended (negative impacts identified)** ○ negative impacts have been mitigated ○ negative impacts balanced against overall positive impacts

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Freedom of Information Act (2000) status	○ **This document is for full publication** ○ **This document includes FOIA exempt information** ○ **This whole document is exempt under the FOIA**

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Paper 10

Legacy Case Review
September 2018

This paper is to update the Trust Board on the progress of cases following a clinical review involving legacy families identified during 2017. The Women & Children's Care Group contacted 31 families on 4 June 2018. Following the legacy paper discussed publicly at the Trust Board in June 2018, further families came forward with questions regarding the review process and also questions related to their care. This was repeated following the media coverage in August 2018 whereby further families came forward. Table 1 below provides a summary:

Table 1

	Contact made	Family responded	Consent received	Expert clinical reviewer appointed
Potential omissions of care delivery (Legacy)	12	12	10	10
No signs of care delivery omissions (Legacy)	19	3	N/A	10
Further families contacting the service (following media coverage)	20	20	N/A	N/A
Total	51	35	10	10

Background

In April 2017, the Secretary of State for Health requested NHS Improvement to undertake an independent review of investigations into a number of historic cases. The cases were named in a letter to the Secretary of State for Health in December 2016 and included new-born, infant and maternal deaths at the Trust. The cases that will be reviewed subject to family consent are those named in the letter in December 2016. The announcement of this investigation in the medial led to the Trust being made aware of legacy families who had concerns and queries about their care over a number of years.

Terms of reference

A Legacy Resolution Group was established, sponsored by the Trust Board Executive Director of Nursing, Midwifery and Quality. There terms of reference were agreed in October 2017 and the group reported to the Quality and Safety Committee: Tier 1 Sub-committee of the Board with formal delegated powers.

Scope of cases
It was important that the Legacy Resolution Group focused on those additional families brought to the Trust's attention. These included cases from between 1998-2017 within the following criteria:

1. Additional families identified by the independent midwife leading the Secretary of State review (not included in the letter to the Secretary of State for Health)
2. Additional families identified who contacted the Trust or NHS Improvement following media coverage
3. Additional families notified to the police by family members following media coverage

Contact with families and the initial consent process
31 families were contacted by registered, signatory required letters on 4 June 2018 following address checks with Trust patient administration systems, General Practitioners and NHS England. This was undertaken to avoid breaches of confidentiality. Of the 31 letters sent, 1 has been returned reporting that the addressee no longer lives at the address, despite checking with the relevant General Practice and NHS England.

Potential omissions of care delivery
The Care Group director has spoken to and written to 12 families to apoloigse and advise that there were potential signs of omissions of care and the seek permission for their case to be reviewed by independent clinical experts. Of the 12 families contacted, 10 have responded and provided consent for external review (to date). Further contact has been made with the final 2 families to expedite the receipt of consent.

No signs of the care delivery omissions
The Care Group director wrote to 19 families to advise that there were no signs of care delivery omissions and offered to meet to discuss the case further with the family. Of the 19 families contacted, the Care Group Director has spoken to 3 families who responded to their letters and discussed the review process. The families have been offered a meeting with the Care Group Director and Head of Midwifery and Clinical Director for Obstetrics (where applicable) to discuss the review process and the care received between 2009 and 2012.

Clinical experts
Clinical experts including Consultant Neonatologist, Consultant Obstetrician Consultant Gynaecologist and Midwife have been identified. The expert instruction has been agreed and those cases that have provided consent have been allocated to each expert. It is expected that the external review process will take up to 6 months, depending on the complexity of issues concerned.

Current activity
Following a media and communication disseminated regarding the legacy case review in June 2018, a further 6 families have contacted the care group, outside the legacy review terms of reference, with queries regarding the Secretary of State review, the Legacy case review and questions regarding their care between 1996 and 2012. The Care Group director has spoken to all 6 families and will be meeting with them all in order to understand their concerns prior to agreeing with the families' further actions and steps.

Following the media coverage in August 2018, a further 14 families have contacted the care group outside the legacy review terms of reference with queries regarding the Secretary of State review, the Legacy case review and questions regarding their care between 1990 and 2009. The Care Group director has spoken to all 14 families and will be meeting with them all in order to understand their concerns prior to agreeing with the families' further actions and steps.

Duty of Candour
The Care Group is committed to ensuring that any learning and improvement is gained from listening to families and hearing their experiences, irrespective of the length of time passed.

The Care Group Director is being open with families and apologising to families where something may be identified as wrong with their treatment of care, has the potential to cause harm or distress. The following choices are being described by the Care Group Director to each family who have approached the Care Group as a potential remedy or support to put matters right:

- Process and support to access health records
- Access to a relevant clinician to help understand clinical records and identify potential omissions in care
- Process and support to access the Trust complaints process
- Process and support to access the Parliamentary Health Service Ombudsman
- Process and support to legally claim for health care negligence

Summary

At the time of the report; a total of **15** of the 31 legacy families have contacted the care group in response to the legacy letters received.

Following the media coverage in June and August 2018; a further **20** families have contacted the care group with queries regarding the Secretary of State review, the Legacy case review and questions regarding their care.