The Shrewsbury and Telford Hospital NHS Trust

Paper 10

Recommendation ☐ **DECISION** ☑ **NOTE**	
Reporting to:	**Trust Board – Public**
Date	**29th November 2018**
Paper Title	**Update of Legacy Case review & further public enquiries**
Brief Description	The Trust Board have received 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 relating to a number of cases that have been brought to the Trusts attention. Following the legacy cases discussed publicly at the Trust Board in June 2018; further families have come forward with questions regarding the review process and also relating to their care. This was repeated following updates at the Trust Board in August 2018, September and October 2018; coinciding with the Trust reports and active invitation for families to come forward if they had concerns regarding their care. The purpose of this paper is to update the Board on progress and describes the current position in relation to the Legacy cases and those families who have come forward.
Sponsoring Director	Deirdre Fowler – Director of Nursing, Midwifery & Quality.
Author(s)	Jo Banks Women & Children's Care Group Director
Recommended / escalated by	Quality & Safety Committee
Previously considered by	Regular updates received by Quality & Safety Committee, Executives and Trust Board
Link to CQC domain	◉ **Safe** ○ **Effective** ○ **Caring** ○ **Responsive** ○ **Well-led**
Link to strategic objectives	**PATIENT AND FAMILY** Listening to and working with our patients and families to improve healthcare **SAFEST AND KINDEST** Our patients and staff will tell us they feel safe and received kind care
Link to Board Assurance Framework	**RR 1204** If the maternity service does not evidence a robust approach to learning and quality improvement, there will be a lack of public confidence and reputational damage
Outline of public/patient involvement	None

Equality Impact Assessment	◉ **Stage 1 only (no negative impacts identified)** ○ **Stage 2 recommended (negative impacts identified)** *** EIA must be attached for Board Approval** ○ negative impacts have been mitigated ○ negative impacts balanced against overall positive impacts
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**

Issue

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 the 4th June 2018. Following the legacy paper discussed publicly at the Trust Board in June 2018, August and September; whereby the Trust encouraged families to come forward; further families have approached the care group with questions regarding the review process and questions relating to their care. Table 1 below provides a summary of the current status of the legacy cases and subsequent enquiries following media coverage of maternity services.

Table 1

	Contact made	Family responded	Consent received	Clinical reviews in progress	Cases complete and closed
Potential omissions of care delivery (Legacy)	12	12	12	12	0
No signs of care delivery omissions (Legacy)	19	3	N/A	2	17
Further families contacting the service	67	55	N/A	N/A	12
Totals	98	70	12	14	29

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 media 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. The 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 focussed on those additional families brought to the Trusts 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 4th 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; reported 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 apologise and advise that there were potential signs of omissions of care and to seek permission for their case to be reviewed by independent clinical experts. Of the **12** families contacted; all **12** have responded and provided consent for external review (to date). All external reviews are now in progress.

No signs of 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; **17** families have not responded and the Care Group director has spoken to **3** families who responded 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. To date one family has met with the relevant clinicians; received a full explanation of the case review process and received answers to the concerns of care.

Clinical experts

Clinical experts including Consultant Neonatologist, Consultant Obstetrician Consultant Gynaecologist and Midwife have been identified. The expert instruction has been agreed and **12** cases have provided consent and allocated to each expert. It is expected that the external review process will take up to 6 months; depending on the complexity of the issues concerned; approximately February 2019.

Further families contacting the care group - Current activity

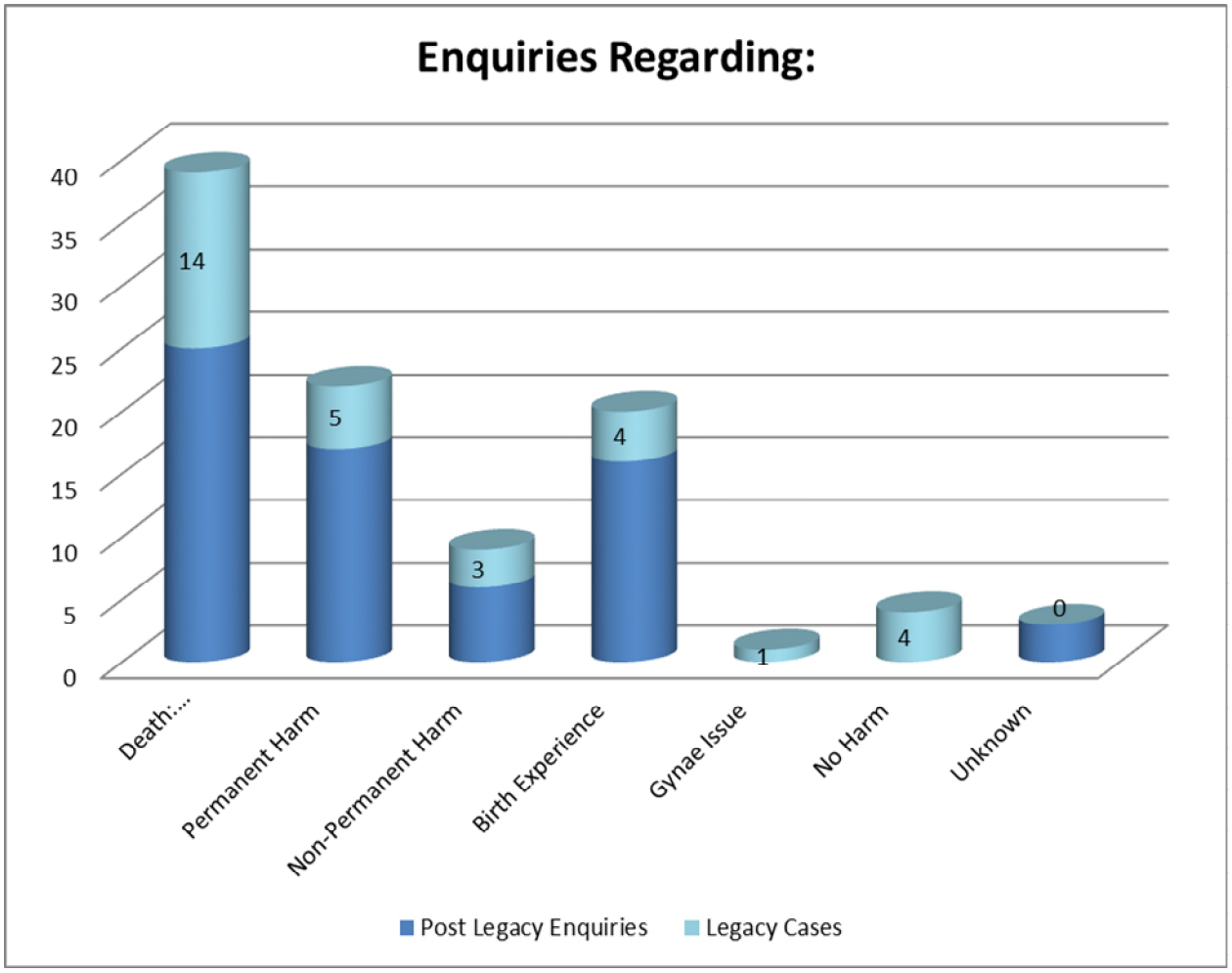
A further **67** families have contacted the care group following the media and communication disseminated regarding the legacy case review and the Trust inviting families to come forward. These cases fall outside of the legacy review terms of reference; with queries regarding the Secretary of State review, the Legacy case review and questions regarding their care between 1973 and 2018.

The Care Group director has communicated with all **67** families in order to understand their concerns prior to agreeing with the families' further actions and steps. Table 2 and 3 indicates the range of issues and queries raised.

Table 2

Enquiries Regarding:	Post Legacy Enquiries	Legacy Cases
Death: (IUD, Intrapartum, Early Neonatal, Late Neonatal, Infant, Paed, Maternal)	25	14
Permanent Harm	17	5
Non-Permanent Harm	6	3
Birth Experience	16	4
Gynae Issue	0	1
No Harm	0	4
Unknown	3	0
TOTAL	**67**	**31**

Table 3



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 or 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 (PHSO)
- 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. **One** legacy case is now closed following resolution with the family.

A further **67** families have contacted the care group following the media and communication disseminated regarding the legacy case review and the Trust inviting families to come forward. Of the **67** cases; **12** are now complete and closed.

28 of the families have requested access to their records pending a meeting with the relevant clinicians to understand and answer their questions where able.