Shropshire Council

Telford & Wrekin COUNCIL

Date: Wednesday, 19 September 2018

Time: 2.00 pm

Venue: Council Chamber, Shirehall, Abbey Foregate, Shrewsbury, SY2 6ND

Contact: Amanda Holyoak, Scrutiny Committee Officer
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JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

TO FOLLOW REPORTS:

4 Shrewsbury and Telford Hospital NHS Trust - Enforcement Action Taken by CQC (Pages 1 - 6)

To receive a report from SaTH detailing the CQC findings, the resultant enforcement action, and SaTH's action plan/response. SaTH are asked to report on any implications for the Business Continuity Plan and the sustainability of both Accident and Emergency Departments. Report attached marked: 4

5 Maternity Services (Pages 7 - 12)

To receive a report on the scope and progress of current investigations and related legal processes and any interim findings, attached marked 5

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The Shrewsbury and Telford Hospital NHS Trust

Recommendation ☐ **DECISION** ☐ **NOTE** (select)	**Joint Health Oversight and Scrutiny Committee** **Purpose:** To receive a report from SaTH detailing the CQC findings, the resultant enforcement action and SaTH's action plan/response. SaTH are asked to report on any implications for the Business Continuity Plan and the sustainability of both Accident and Emergency Departments.
Reporting to:	**Joint Health Oversight and Scrutiny Committee**
Date	19 September 2018
Paper Title	**Shrewsbury and Telford Hospital NHS Trust - Enforcement Action Taken by CQC**
Brief Description	This paper seeks to provide the Joint Committee with further information relating to the initial findings of the CQC, the requirements of the conditions imposed on the regulated activity and the response from the Trust and our action plan going forward. Additionally, implications for the Business Continuity Plan and the sustainability of both ED will be reported upon. In August 2018 the Care Quality Commission (CQC) visited Shrewsbury and Telford Hospital NHS Trust (SaTH) as part of a structured formal albeit unannounced inspection process. At this visit the CQC raised concerns specifically related to the care of patients within our Emergency Department (ED) at Princess Royal Hospital (PRH) and the practice of placing additional patients on wards (known as "boarding"). Subsequently, the CQC formally notified the Trust that under Section 31 of the Health and Social Care Act 2008 they intended to impose conditions related to the regulated activity Treatment of disease, disorder or injury that related to the ED at both sites relating to the care of deteriorating patients and the environment in the ED at PRH. The Trust has a plan in place to ensure that we meet the requirements of the conditions to provide assurance to the CQC that we have a robust action plan in place to address the concerns raised and that we meet the requirement to submit weekly reports to provide that assurance. Since 2014 the Trust Board and wider system have been updated on the significant workforce challenges that have met the Emergency Departments at RSH and PRH. This risk was, and remains, the greatest risk on the Trust Board Assurance Framework and Trust Risk Register. It has previously also formed part of the programme of review and scrutiny by the Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin. The recent CQC unannounced visit in September 2018 identified significant concern in relation to the management and escalation of patients who may present with sepsis or a deteriorating medical condition in both ED. This has been significantly influenced by the ongoing workforce challenges the EDs are experiencing and demonstrates that the sustainability of both Accident and Emergency Departments is challenged . As a result, the case for change is strengthened and the options detailed in the paper will be considered in detail by

	the Trust Board later in September.
Sponsoring Director	Deirdre Fowler, Director of Nursing, Midwifery and Quality
Author(s)	Helen Jenkinson, Deputy Director of Nursing and Quality
Recommended / escalated by (Tier 2 Committee)	None
Previously considered by (consultation / communication)	**None**
Link to strategic objectives	
Link to Board Assurance Framework	
Outline of public/patient involvement	
Equality Impact Assessment (select one)	● **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 (select one)	● **This document is for full publication** ● **This document includes FOIA exempt information** ● **This whole document is exempt under the FOIA**

Inspection Process

In August 2018 the Care Quality Commission (CQC) carried out an unannounced visit to Shrewsbury and Telford Hospital NHS Trust (SaTH) as part of a formal inspection process. The CQC review the services of the Trust based on the following key lines of enquiry to measure whether services are:

Safe: Patients are protected from physical, psychological or emotional harm or abuse

Effective: Patients needs are met and care is in line with national guidelines and standards and promote best chance of getting better

Caring: Patients are treated with compassion, respect and dignity and that care is tailored to their needs.

Responsive: Patients get the treatment or care at the right time, without excessive delay, and are involved and listened to

Well Led: There is effective leadership, governance and clinical involvement at all levels and a fair, open culture exists which learns and improves from listening and experience.

The inspection team visited areas within the organisation, talked to patients, their carers and the staff and reviewed written records in order to measure compliance against systems and processes.

Following the initial visit the CQC have revisited the Trust to better understand their initial findings and to gain assurance that any immediate actions that were required have been carried out. In addition to the visit to the Trust the CQC may request supporting documentation and to date (12 September) 485 data requests have been received.

Findings of the Initial Inspection and Notice to Impose Conditions

The Committee will be aware that following their initial visit in August the CQC raised serious concerns related to the care of patients within our Emergency Department (ED) at Princess Royal Hospital (PRH) and the practice of placing additional patients on wards (known as “boarding”). The Committee is asked to note that the Trust has not had any additional patients on the wards since 22 August 2018.

Subsequently, on 05 September 2018, the CQC formally notified the Trust that under Section 31 of the Health and Social Care Act 2008 they intended to impose conditions related to the regulated activity “Treatment of disease, disorder or injury”.

The conditions that were served on the Trust on 05 September 2018 were:

- The Registered Provider must ensure that there is an effective system in place to identify, escalate and manage patients who may present with sepsis or a deteriorating medical condition in line with the relevant national clinical guidelines. This applies to all patients in all areas of the emergency departments at the Princess Royal and the Royal Shrewsbury Hospitals.

- The Registered Provider must ensure that the emergency department premises at the Princess Royal Hospital are safe for their intended purpose with equipment stored safely. The Registered Provider must ensure that risk assessments are carried out and reviewed to ensure that the environment remains safe for its intended purpose and that all staff are aware of and adhere to protocols

Requirements of the Conditions

In order to provide assurance to the CQC that we are progressing with the actions required under the conditions that have been imposed, the Trust is required to provide a report on a weekly basis describing specific actions under each of the two conditions above.

In order to achieve this, a report template has been devised and a process put into place to ensure Executive scrutiny and sign off prior to submission each week.

Implications for the Business Continuity Plan and the sustainability of both ED

Since 2014 the Trust Board and wider system have been updated on the significant workforce challenges that have met the Emergency Department at RSH and PRH.

In March 2016 the public meeting of the Trust Board received a paper outlining a number of options to maintain safe and effective urgent and emergency care services. This paper followed on from an earlier paper received at the public meeting of the Trust Board in December 2015 which outlined the risks and challenges being faced at that time in relation to maintaining two emergency departments at the PRH and RSH sites.

This risk was, and remains, the greatest risk on the Trust Board Assurance Framework and Trust Risk Register. It has previously also formed part of the programme of review and scrutiny by the Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin.

A presentation was given at the Trust Board in August 2018 by Edwin Borman (Medial Director) and Nigel Lee (Chief Operating Officer) that described the current work that is being progressed to review the business continuity plans. It also highlighted that there would be a paper presented to Trust Board in September 2018 requesting a decision to be made in relation to three options:

Option 1 - Maintain existing dual site ED service

- Continue to request support from neighbouring Trusts for additional medical resource to maintain two ED
- Consultants maintain rota by acting down as Middle Grade support
- Measure and respond to risks on a shift by shift basis
- Continue to work up short and long term business continuity and service development plans
- Maintain workforce recruitment strategy

Option 2 - Close PRH ED from 20:00 – 08:00

- Last ambulance @ 20:00, walk-in patients accepted at 20:00 (divert plan thereafter)
- UCC will accept patients via CCC until 22:00
- Some remaining patients would remain in ED into the night until pathway for discharge or admission available
- PRH will continue to accept GP referred admissions in those specialities managed at PRH
- Ambulance divert to neighbouring Trusts so as to not over stretch RSH ED and create additional risk for emergency paediatric and ENT patients.

Option 3 - Close RSH ED from 20:00 – 08:00

- Last ambulance @ 20:00, walk-in patient accepted at 20:00 (divert plan thereafter)
- UCC will accept patients via CCC until 22:00
- Some remaining patients would remain in ED into the night as currently admitted under ED until pathway for discharge or admission available
- Trauma Unit status would need to be revoked
- Ambulance divert to neighbouring Trusts so as to not over stretch PRH ED and create additional risk for emergency surgical and trauma patients

The recent CQC unannounced visit in September 2018 identified significant concern in relation to the management and escalation of patients who may present with sepsis or a deteriorating medical condition in both ED. This is a significant outcome of the onging workforce challenges that the ED are experiencing and demonstrates that the sustainability of both Accident and Emergency Departments is challenged . As a result, the case for change is strengthened and Option 2 or Option 3 needs to be fully considered by the Trust Board on 27 September 2018.

Services have completed quality impact assessments in relation to all three options and this will form part of the intelligence that will be provided to enable the Board to make a decision on the options.

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The Shrewsbury and Telford Hospital NHS Trust

Recommendation ☐ **DECISION** ☐ **NOTE** (select)	**Joint Health Oversight and Scrutiny Committee** **Purpose:** To receive a report from SaTH detailing the update of the Legacy Case Review
Reporting to:	**Joint Health Oversight and Scrutiny Committee**
Date	19 September 2018
Paper Title	**Update of Legacy Case Review**
Brief Description	This paper seeks to provide the Joint Committee with further information 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; 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 Joint Committee 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, Women's & Children Care Group Director
Recommended / escalated by (Tier 2 Committee)	None
Previously considered by (consultation / communication)	**None**
Link to strategic objectives	
Link to Board Assurance Framework	
Outline of public/patient involvement	

Equality Impact Assessment (select one)	● **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 (select one)	● **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 joint committee on the progress of cases following a clinical review process involving 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; 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. Table 1 below provides a summary of the current legacy cases and subsequent enquiries following media coverage of maternity services.

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 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; **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 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 the issues concerned.

Current activity

Following the 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 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
- 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.

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