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.