**Supplementary information for Joint Health Overview and Scrutiny Committee (Yorkshire and Humber) on 10 April 2014**

Pages 1-2: Agenda item 7 – Copy of letter dated 3 April 2014 from Dr Mike Bewick, Deputy National Medical Director, NHS England to Councillor John Illingworth (Chair of Joint Health Overview and Scrutiny Committee (Yorkshire and Humber)

Pages 3-16: Agenda item 8 – The following information was provided:

- QSG minutes held on 19 February 2014
- QSG follow up notes held on 26 February 2014
- QSG minutes held on 7 March 2014
- Risk summit minutes held on 7 March 2014
- LTHT update on progress against recommendations.

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**Councillor John Illingworth**
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(sent by email only)
3 April 2014

Dear Councillor Illingworth,

I write in response to your email of 11 March 2014 and other emails regarding your requests for information on behalf of the Yorkshire and Humber Joint Health Overview and Scrutiny Committee (JHOSC) made pursuant to the Local Authority (Public Health, Health and Wellbeing Boards, and Health Scrutiny) Regulations 2013 (Health Scrutiny Regulations).

NHS England agrees with you that requests for information under the Freedom of Information Act 2000 (FOIA) and the Health Scrutiny Regulations are two separate processes, but notes that the Health Scrutiny Regulations do not provide JHOSCs an unrestricted right to access information held by NHS England, nor an obligation to provide information in an unredacted format.

*Information required to be provided to the JHOSC*
As you are aware, Regulation 26 of the Health Scrutiny Regulations states that 'responsible persons' (such as NHS England) must provide local authorities or joint overview and scrutiny committees (such as the Yorkshire and Humber JHOSC) such information about the planning, provision and operation of health services in the area of the local authority/committee, as may reasonably be required by the authority/committee in order to discharge its relevant functions.

On this basis, the information that NHS England is required to provide in response to your request is not unlimited. NHS England is only required to provide that information which the JHOSC reasonably requires to discharge its relevant functions.

NHS England considers that, for present purposes, the JHOSC's relevant functions are those related to children's congenital heart disease services. However, you have made a very broad request (i.e. "*a complete and un-redacted disclosure of all the email correspondence, and associated letters and reports that refer to the Leeds Teaching Hospitals NHS Trust that have passed through Sir Bruce Keogh's office between 1 March 2013 and the present day.*"). It seems to us therefore that much of the information

thus sought would have no bearing on the JHOSC's ability to discharge the relevant functions here. Of course, should you consider we are wrong about that, we would be happy to hear from you with your reasons for that view. Alternatively, you may wish to narrow your request to ensure that it relates specifically to the JHOSC's functions in this matter.

Upon receipt of the necessary clarification, NHS England will provide you with the information that is reasonably necessary for the discharge of your functions. However, while we note your request for unredacted correspondence, NHS England is not required to provide information in this form, whether pursuant to Regulation 26 of the Health Scrutiny Regulations or otherwise.

*Redaction*
Regulation 26 includes restrictions on the information that can be released to the local authority/committee. In particular, we note that NHS England is not required to provide confidential information that relates to, and identifies, an individual, unless the person consents to that information being disclosed, or the information is (or can be) disclosed in a form from which the identity of the person cannot be ascertained. NHS England can also (and in fact must) properly withhold information where its disclosure would be prohibited by any other law.

However, the Health Scrutiny Regulations provide that if the only prohibition on the release of the information is the fact that it contains information capable of identifying a person, and the information can be redacted so that the identity of the person cannot be ascertained, then the information should be provided in that (redacted) form.

Accordingly, any information that you receive in due course may be provided in a redacted format, but the only information that will have been removed is that relating to individuals.

Regarding the JHOSCs request for Sir Bruce Keogh to attend on 10 April, unfortunately Bruce will be attending a family funeral that day and will not be able to attend. However, as you will be aware, I have been leading on such LTHT matters on his behalf and I will be happy to attend the JHOSC in my capacity as both his deputy and as Chair of the Risk Summit (April 2013).

I look forward to hearing from you.

Yours sincerely

**Dr Mike Bewick**
Deputy National Medical Director
NHS England

QSG:

Re: The Leeds Teaching Hospital Trust Paediatric Cardiac Surgery service

19th February 2014

Attendees/Dial in:

1. (GH) Gill Harris, Chief Nurse – NHS England North (Chair)
2. (MB) Mike Bewick, Deputy Medical Director – NHS England
3. (DW) Debbie Westhead, Acting Regional Director – CQC
4. (SC) Sue Cannon, Director of Nursing – West Yorkshire Area Team
5. (AB) Andy buck, Area Director – West Yorkshire Area Team
6. (MC) Maureen Choong, Clinical Quality Director North – NHS Trust Development Authority
7. (DR) Damian Riley, Medical Director – West Yorkshire Area Team / Acting Medical Director – NHS England North
8. (CR) Caroline Radford, Head of Communications – NHS England North
9. (NP) Nicola Pollard, Executive Assistant to Gill Harris – NHS England North (taking minutes)

Purpose:

GH welcomed members of the QSG and thanked them for attending or dialling in

GH recognised that The Leeds Teaching Hospital Trust (LTHT) is under new leadership changes and recognises the significant new feel to the organisation from 12m ago

GH put context around the meeting, QSG will recall the activity nearly 12m ago regarding Leeds children cardiac surgery. Following on from this a number of risk summits and single item QSGs were called. From this specific work streams were requested:

1. ***Mortality Report, DR to update***
2. ***Pat Cantrill Report, AB/SC to update***
3. ***Investigation of concerns raised by other Trust, MB to update***

**3rd strand to phase 2 investigation**: Verita investigation

MB advised the group that following on from the letter and concerns raised in the letter from the other Trust, that Verita have contacted families involved and will be working with them to create a report. This will be a standalone report and will hopefully be published later this year. This report was commissioned by the QSG and will be received for sign off when available by the QSG. Coordinated by the NHS England central team and led by MB.

AB asked the group who from NHS England have been interviewed by Verita. The group were advised that GH, AB and DR had been contacted. AB has been interviewed, the others not yet. . Issue was raised to how will the interviews be used and will transcripts be used.

*ACTION: NP to contact MBs office to source the Term of References (TOR) from Verita and will circulate them to the QSG. Any questions regarding the TOR to be raised to MB*

GH requested an update regarding Bristol Royal Hospital For Children due to recent press coverage and similarities with Leeds. MB advised the group that Bristol has normal quantitative data and shows no outliers or areas of concern from angle of mortality. However, a number of concerns have been raised by service users and their families regarding staff not being able to provide compassionate care to patients. Particular concern raised regarding the post-operative ward. Staffing ratio is being looked at.

**Mortality Report**:

GH reminded the group that this reports needs to be ratified by the group

DR updated the group on recent changes. All patient identifiable data has been removed. Bruce Keogh has requested sight of report.

The group reviewed the report, section by section enabling the group to raise any questions or point for clarification

35 cases were looked at for this report, 31 cases had no omission of care. 4 cases were drawn to the attention of the Trust by the review team, and required follow up from the Trust. It was important to recognise that these were cases where the external review team thought the Trust might want to further analyse *the way* the Unit gives care. In no instance did the reviewers conclude that had the care or operation been done differently, that the patients would have survived instead of patient not surviving. Example: patient being taken to theatre 3 times in 24hours, no second surgeon called. Trust's HR and internal investigation processes are dealing with this. *It is known that the surgeon who this relates to is not operating, and had stopped doing so before March 28th 2013.*

*ACTION: AB requested we clarify the date of last operation carried out by this surgeon*

Table of recommendations were reviewed. GH raised the point that in this the Trust state they send monthly reports to NHS England.

*ACTION: MB to explore where these reports are going to and to get copies for the QSG (Subsequently clarified they go to spec comm team in S Yorks)*

GH requested each agency to sign off this report as a member of QSG, particularly focussing on the recommendation and to make note that they are agreeing to this format and agree that minor textual changes may occur.

Each agency verbally agreed they were happy with the report.

*ACTION: GH to write to Bruce Keogh with final draft version the report*.

**Pat Cantrill Report**:

AB updated the group, referring to draft 7 of the report. This draft now takes into accounts comments from QSG members and includes more quotes from patient's stories.

AB raised four points to the group:

1. Pat Cantrill not yet gone back to parents to gain their permission to publish the report with their quotes. This will be an issue of the entire patients story is repeated in the report since these patients will be identifiable and they may not wish further intrusion into their privacy and grief.
2. LTHT yet to see the report
3. Bruce Keogh yet to review the report
4. DR suggested NHS England , through Area Team, asking Pat to review the format, to create a synopsis and themed findings, to include more families' quotes, at least one from every family interviewed, and to build some recommendations . DR was happy to work with Pat to do this.

It was agreed a thematic review should be included, discussing key themes and recommendations

Trust will be requested to respond the report of how thing will/or have changed once it is released.

The group agreed that patient stories are compelling, they show the lessons to belearned. The group feel parents will feel they have been heard and agreed the use of many quotes would be powerful element of the report.

GH suggested that the Trust should see this report in draft format.

*ACTION: AB, SC and DR to work on reports with Pat C to form a thematic review. Deadline 7th March*

**Communications:**

NHS England will need to contact the parents of the families involved to advise them that this report will be published

LTHT have agreed that they will contact the 35 families who were involved in the mortality review to advise them of the report. The 31 families who had no issues will receive a letter and the 4 families who required follow up from the trust will called personally by the Trust.

MB suggested a follow up letter from NHS England to all families involved

CR advised the group that the media and local MPs will be advised of the reports.

ACTION: CR/GH/MB to draft letters to the families

ACTION: CR to produce an overarching comms plan to ensure key stake holders are aligned and to work with LTHT

ACTION: NP to work with MBs office to get LTHTs availability for a review meeting with the QSGas a follow up risk summit

**Next meeting, 26th February**

QSG follow up call

Re: The Leeds Teaching Hospital Trust Paediatric Cardiac Surgery service

26th February 2014

Attendees:

1. (GH) Gill Harris, Chief Nurse – NHS England North (Chair)
2. (SC) Sue Cannon, Director of Nursing – West Yorkshire Area Team
3. (MC) Maureen Choong, Clinical Quality Director North – NHS Trust Development Authority
4. (DR) Damian Riley, Medical Director – West Yorkshire Area Team / Acting Medical Director – NHS England North
5. (CR) Caroline Radford, Head of Communications – NHS England North
6. (NP) Nicola Pollard, Executive Assistant to Gill Harris – NHS England North (taking minutes)

GH welcomed members of the QSG and thanked them for attending the call/meeting

DR - Ongoing changes to format of Pat Cantrill Report and Mortality Review, minor wording changes, reports to have final sign off on Friday 7th March morning QSG meeting, prior to meeting with the Trust in the afternoon.

DR - Terms of reference now appended to Pat Cantrill report as opposed to in body of report, and she has signed off the recommendations

CR - NHS England Communications team working closely with LTHT Commutations team to ensure the letters to families are sent prior to the publication of the reports. 7 different tailored letters being drafted dependant t on what report the family was involved in.

CR - NHS England Communications team have circulated the time line to the QSG members and it is vital that the group stick to these timings to ensure that the report is published on the NHS England website on 13th March 2014

*ACTION: final versions of reports to be sent to QSG members ahead of Friday 7th March sign off meeting*

*ACTION: letters to be signed off by GH/MB, CR to continue to work with LTHT on sending the letters and gaining names and addresses of the families*

**Next QSG Meeting: 7th March 2014**

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QSG: Friday 7th March 2014

Re: The Leeds Teaching Hospital Trust Paediatric Cardiac Surgery service

Attendees (in person or dial-in):

1. (GH) Gill Harris, Chief Nurse – NHS England North (Chair)
2. (MB) Mike Bewick, Deputy Medical Director – NHS England
3. (MBB) Malcom Bower Brown, Regional Director North – CQC
4. (SC) Sue Cannon, Director of Nursing – West Yorkshire Area Team
5. (AB) Andy buck, Area Director – West Yorkshire Area Team
6. (MC) Maureen Choong, Clinical Quality Director North – NHS Trust Development Authority
7. (DS) Dean Spencer, Associate Director – NHS Trust Development Authority
8. (DR) Damian Riley, Acting Medical Director – NHS England North
9. (CR) Caroline Radford, Head of Communications – NHS England North
10. (NP) Nicola Pollard, Executive Assistant to Gill Harris – NHS England North (taking minutes)

**Purpose:**

GH welcomed the group

GH advised the group that the reason for today's QSG was for all QSG agencies to sign off reports and consider NHS England's response to the reports, this will be the covering document to the 2 reports.

The 2 reports and response will be printed/sent/viewed online as a single document.

The QSG will meet with The Leeds Teaching Hospital Trust later in the day to discuss the reports.

Letters have been sent to all families involved in the reports which were signed off my MB and GH

**Pat Cantrill Report**

DR updated the group on recent changes. DR had shown group that Pat was content with the way report was being formatted now. The latest iteration is draft version 14. It is the formatting of the patients stories that have changed; Pat has incorporated some element of each family's experience in the latest version. Report now has incorporated themes and added recommendations for Trust to consider.

The group were asked to make any final comments.

Minor textual changes were suggested

The group were in agreement to rename the report "Family Experience Report"

The group agreed to the subheading "Thematic analysis of the experience, views and concerns of some of the parents whose children received care from Leeds Teaching Hospitals NHS Trust Children's Cardiac Services between 2009 - 2013."

The group agreed that a recommendation in terms of equality and diversity should be added to the overarching reporting

*ACTION: DR to liaise and make changes and the final version of this report will be version 15.*

The QSG were in agreement of proposed Version 15, the final document and have further no further amendments

NB: The report was commissioned by NHS England, on behalf of QSG and not by the Trust

**Morality Case Review**

The QSG reviews the final version of this report

This report was ratified by group subject to very minor formatting changes. Clearer specification of recommendation regarding echo-result filing has been made. DR had shown group that the external reviewers were content with the report.

**NHS E response – not CQC/TDA/LHTH**

The group agreed that this response will be the cover note/document to the reports

ACTION: GH/MB/DR to work with CR on this response

**Communications**

MB updated the group on concerns raised by the Trust regarding staff being identifiable in the reports

**CQC**

No further comments on the reports

LTHT has their CQC inspection on 17th March

Risk Summit

Review Meeting with QSG Members & The Leeds Teaching Hospital Trust

Friday 7th March 2014

Attendees:

1. (GH) Gill Harris, Chief Nurse – NHS England North (Chair)
2. (MB) Mike Bewick, Deputy Medical Director – NHS England
3. (MBB) Malcom Bower Brown, Regional Director North – CQC
4. (SC) Sue Cannon, Director of Nursing – West Yorkshire Area Team
5. (AB) Andy buck, Area Director – West Yorkshire Area Team
6. (MC) Maureen Choong, Clinical Quality Director North – NHS Trust Development Authority
7. (DS) Dean Spencer, Portfolio Director – NHS Trust Development Authority
8. (DR) Damian Riley, Acting Medical Director – NHS England North
9. (CR) Caroline Radford, Head of Communications – NHS England North
10. (NP) Nicola Pollard, Executive Assistant to Gill Harris – NHS England North (taking minutes)
11. (JH) Julian Hartley, Chief Executive – The Leeds Teaching Hospital Trust
12. (YO) Yvette Oade, Chief Medical Officer – The Leeds Teaching Hospital Trust
13. (BG) Bryan Gill, Consultant Neonatal Medicine – The Leeds Teaching Hospital Trust
14. (JW) Jane Westmoreland, Head of Communications – The Leeds Teaching Hospital Trust

**Background**

GH provided the group with an overview and background to the purpose to today's Risk Summit, and the opportunity to have a review meeting with the new leadership team at The Leeds Teaching Hospital Trust (LTHT).

The Risk Summits / QSGs are in response to the Trust suspending services 12m ago following on from the Sir Bruce Keogh visit

GH gave background to what a QSG and Risk Summit is and reminded the group that the QQG commissioned pieces of work and this uplifted Leeds suspension of services.

GH discussed the recent work and sign off the final reports which consists of an short overarching document which is NHS England's response (to be written by Mike Bewick), incorporating the family review and the mortality review reports

Printed versions of the reports were shared with the Trust, the Trust have had sight of earlier draft versions. The Torts were aware of the mortality report findings for some months and were co-commissioners. The Family Experience Report was only recently finalised.

GH requested that each report is talked through and the lead for each report updated the Trust on recent changes from earlier drafts.

*ACTION: NP to circulate final versions of the reports electronically to the Trust*

GH advised the Trust that they have time to review the reports

**Mortality Review**

DR updated the group on small changes made to the latest version, which is date 5th March 2014, a formatting of summary paragraphs. No changes to findings since original draft in 2013.

BG requested the change of formatting of one paragraph on page 3. The group agreed this is fine

DR advised the group that a small change was made to one the recommendations; an external review team member had wished to stress the need for a standardised way of filing post-op echo, and the recommendation was amended to make this more explicit. The Trust and QSG supported the change

The QSG have ratified the report

**Family Experience Report**

GH reiterated that this report was commissioned by NHS England on behalf of the QSG

AB gave background to the report

It was noted that an Equality and Diversity recommendation was added as a further specific recommendation in the overall response to the report in light of certain specific findings

The findings will be grouped into 5 key themes, and NHS England will provide an overview document to support this report.

DR advised the Trust that the Pat Cantrill report will now be named the Family Experience Report.

BG asked the group to consider how the report will be viewed if it is read alone: AB/GH reiterated that the report will be part of the overarching report with an overarching document to be published with the reports to bring the reports together

*ACTION: CR to make the reports and overarching report one document for publication with input from QSG members*

**Verita Report**

MB updated the group on the Verita report. This work came out of the correspondence from another NHS Trust.

Families involved were being contacted and interviewed

LTHT and the team at the other Trust will also be interviewed

The work will be published as a report but it will go through the QSG process. It is being coordinated by NHS England central team (MB leading)

The process has taken longer than expected due to procurement issue and issues for 2 trusts to agree on dates and release records.

YO said that LTHT have dealt with Veritas requests in a timely manner. MB said he was aware of this.

YO raised an issue on behalf of the Trust regarding the publication, reflecting likely media interest in the Trust, this was acknowledged by the QSG

This investigation is not completed, will take several weeks yet, so report not yet ready to publish.

BG raised point that Verita interviews are scheduled for 17th March, the trust feel this is very close to the time of the publication of the other reports.

*ACTION: MB to discuss the sensitively of the interview dates with Verita*

**Trust response**

JH found the Family Experience Report very upsetting and found the stories devastating to read.

JH acknowledged that from the Trust's point of view a lot of learning has come from the accounts. LTHT has a commitment to change. JH acknowledges that the QSG and LTHT need to work together to respond.

JH thanked the QSG for the management of Mortality Review, JH felt the engagement between agencies worked well and the message the report gives out.

JH thanked AB for sharing the Family Experience Report. But highlighted that the report presents the Trust with a media story to address.

LTHT communications team need to get balance right on how to respond as there was also a duty to the individual families involved.

JH raised the point that the report focusses on 16 shocking stories, and does not detail the 1000's of good experience the Trust has and this will be the main focus in the press.

The Trust's highlighted the risk of the identification of an individual staff within the report and that a small number of highly skilled staff that carry out certain procedures may be destabilised by criticisms which there has been no way to validate.

BG raised the point about current staff and how they will feel when report comes out and said the Trust has a plan to address Unit staff next week.

Concern raised that following publication families may wish to transfer care. NHS England confirmed established processes to support this if required.

**Reflection and Summary**

GH summarised the outcomes from today's meeting

1. The QSG received the reports in their final draft. The QSG acknowledge there is a risk relating to staff being identified. The QSG and the Trust will work together to manage the risk and provide the overarching document to support the two reports. The QSG and the Trust will work collaboratively to put contexts around the report to reflect on learning from LTHT in the last 12m
2. NHS England and LTHT Comms team to work together on covering letter to the families who will be receiving the report next week
3. Overarching cover note will be drafted by MB and signed off by QSG and shared with LTHT
4. GH has request a sit rep today in case of escalation, processes in place to manage any changes in referral and transfers over next 2 weeks. Engagement with LTHT crucial
5. LTHT will review the recommendations made in the Family Experience Report

ACTION: Overarching cover note will be drafted and signed off by QSG and LTHT

**Closing remark**

GH would like to, on behalf of the QSG thank:

LTHT for their support and openness

Pat Cantrill and acknowledge the work that has been undertaken to produce her report

External contributors to the Mortality review

The Leeds Teaching Hospitals NHS
NHS Trust

**Update on progress against recommendations from the phase 1 - Rapid Review**

**Joint Health Overview and Scrutiny Committee**

**Thursday 10 April 2014**

## 1.0 Background and introduction

1.1 On 28 March 2013, Leeds Teaching Hospitals NHS Trust paused children's cardiac surgery pending the outcome of an investigation into concerns raised by Sir Bruce Keogh, then medical director for the Department of Health.

1.2 A Quality Surveillance Group convened by NHS England on 2 April 2013 agreed that a review would be carried out to consider the concerns raised.

1.3 This review had two phases.

- **Phase 1 (Rapid Review)** – an urgent review of LTHT's children's cardiac surgery unit to ascertain if there were significant and readily identifiable safety concerns. The review would focus on clinical governance processes, staffing capacity and capability and patient experience.
- **Phase 2** – consisted of three components.
  1. Mortality Case Review
  2. Family Experience Review
  3. Governance Review

1.4 The Rapid Review took place during 5-7 April 2013 and found no evidence of immediate significant safety concerns in terms of clinical governance, staffing or in the management of the patient pathway for surgical care in the Leeds service or for referral to other units. Surgery recommenced on 10 April 2013.

1.5 The Rapid Review identified a number of areas of good practice at the Leeds Unit and also made a number of recommendations for further improvements to the service.

1.6 This paper provides an update against the recommendations made in the Phase 1 Rapid Review including details of where progress has been reported and considered.

## 2.0 Rapid Review – 5-7 April 2013

2.1 The Rapid Review was carried out during 5-7 April 2013 by an external and independent review team.

2.2 The review identified a number of areas of good practice across the Leeds Unit and also made a number of recommendations around areas for further improvement and where processes could be strengthened.

These areas included:

- Incident management
- Risk management
- Complaints and real time patient feedback
- Data management
- Audit
- Staffing capacity and capability
- Patient pathways/experience

2.3 The recommendations were developed into a Trust Development Authority action plan for the Trust to action and report on at monthly performance meetings. This included clear timescales for completion.

2.4 The Trust has addressed all of the recommendations set out in the action plan within the timescales agreed. There is one recommendation around ward sisters taking an 80% supervisory/ leadership role which is due for completion in 2015.

2.5 During the last 12 months, the Trust has reported on progress against the action plan to its Quality Committee (a formal sub-committee of the Board) three times and the Chair of this committee has provided updates to the full Board.

2.6 Progress has also been monitored by the Trust Development Authority through the Trust's regular monthly performance reporting meetings.

2.7 An update on progress against the recommendations has also been shared with NHS England.

**3.0 Phase 2 review – update on progress against recommendations**

3.1 Phase 2 consists of three components. The findings from the Mortality Case Review and the Family Experience Review were published in March 2014. Both reports identified areas where the Trust can improve further.

3.2 Mortality Case Review –this review found the service to be safe. The Trust has already actioned all of the recommendations made from this review and will continue to work with NHS England as these findings are fed into its wider review around congenital heart disease services nationally.

3.3 Family Experience Review – a number of areas were identified where Leeds Teaching Hospitals NHS Trust can improve its service for families. These areas are currently being developed into tangible actions that we can implement to ensure we provide the best possible services for families. Again, the findings from this report will be fed into NHS England's wider review around congenital heart disease services nationally.

3.4 Progress against these recommendations is being reported to the Trust's Quality Committee and full Board and to the Trust Development Authority and NHS England.