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