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