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.