The Shrewsbury and Telford Hospital NHS Trust

Paper 13i

Recommendation ☐ DECISION ☑ NOTE	**Trust Board** is asked to note the Legacy Review update
Reporting to:	**Trust Board – Public**
Date	**25th October 2018**
Paper Title	**Update of Legacy Case review & further public enquiries**
Brief Description	The Trust Board have received updates 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. Following the legacy cases discussed publicly at the Trust Board in June 2018; further families have come forward with questions regarding the review process and also relating to their care. This was repeated following updates at the Trust Board in August 2018 and September 2018; coinciding with the Trust reports and active invitation for families to come forward if they had concerns regarding their care. The purpose of this paper is to update the Board on progress and describes the current position in relation to the Legacy cases and those families who have come forward.
Sponsoring Director	**Deirdre Fowler – Director of Nursing, Midwifery & Quality.**
Author(s)	**Jo Banks Women & Children's Care Group Director**
Recommended / escalated by	**Quality & Safety Committee**
Previously considered by	Regular updates received by Quality & Safety Committee, Executives and Trust Board
Link to CQC domain	◉ **Safe** ○ **Effective** ○ **Caring** ○ **Responsive** ○ **Well-led**
Link to strategic objectives	**PATIENT AND FAMILY** Listening to and working with our patients and families to improve healthcare **SAFEST AND KINDEST** Our patients and staff will tell us they feel safe and received kind care
Link to Board Assurance Framework	**RR 1204** If the maternity service does not evidence a robust approach to learning and quality improvement, there will be a lack of public confidence and reputational damage
Outline of public/patient involvement	None

Equality Impact Assessment	(•) **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	(•) **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 Trust Board on the progress of cases following a clinical review involving legacy 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, August and September; whereby the Trust encouraged families to come forward; further families have approached the care group with questions regarding the review process and questions relating to their care. Table 1 below provides a summary of the current status of the legacy cases and subsequent enquiries following media coverage of maternity services.

Table 1

	Contact made	Family responded	Consent received	Clinical reviews in progress	Cases complete and agreed with family
Potential omissions of care delivery (Legacy)	12	12	12	11	0
No signs of care delivery omissions (Legacy)	19	3	N/A	2	1
Further families contacting the service	50	47	N/A	N/A	4

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; all **12** have responded and provided consent for external review (to date).

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. To date one family has met with the relevant clinicians; received a full explanation of the case review process and received answers to the concerns of care.

Clinical experts

Clinical experts including Consultant Neonatologist, Consultant Obstetrician Consultant Gynaecologist and Midwife have been identified. The expert instruction has been agreed and 11 cases have provided consent and allocated to each expert. One final consent has been received and the external experts are in progress of allocation. It is expected that the external review process will take up to 6 months; depending on the complexity of the issues concerned; approximately February 2019.

Current activity

A further **50** families have contacted the care group following the media and communication disseminated regarding the legacy case review and the Trust inviting families to come forward. These cases fall outside of the legacy review terms of reference; with queries regarding the Secretary of State review, the Legacy case review and questions regarding their care between 1973 and 2017. The Care Group director has communicated with all 50 families 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 (PHSO)
- 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. **One** legacy case is now closed following resolution with the family. A further **50** families have contacted the care group following the media and communication disseminated regarding the legacy case review and the Trust inviting families to come forward. **Four** of the families have had access to their records, met with the relevant clinicians and their case is now closed following resolution with the family.

Paper 13ii

Recommendation ☐ DECISION ☑ NOTE	**Trust Board to note the maternity clinical dashboard for August 2018**
Reporting to:	**Trust Board**
Date	25 October 2018
Paper Title	Maternity Clinical Dashboard
Brief Description	The purpose of this report is to provide the Trust Board with an analysis of data within the maternity clinical dashboard for August 2018. The report highlights any elements by exception and indicates a description for the indicators that are not aligned with local or national targets
Sponsoring Director	Nigel Lee - Chief Operating Officer
Author(s)	Anthea Gregory-Page – Deputy Head of Midwifery
Recommended / escalated by	N/A
Previously considered by	Quality & Safety Committee Clinical Quality Review Meeting
Link to strategic objectives	SAFEST AND KINDEST - Deliver the kindest care in the NHS with an embedded patient partnership approach
Link to Board Assurance Framework	If we are unable to implement our clinical service vision in a timely way then we will not deliver the best services to patients (RR 668)
Equality Impact Assessment	◉ **Stage 1 only (no negative impacts identified)** ○ **Stage 2 recommended (negative impacts identified)** ○ negative impacts have been mitigated ○ negative impacts balanced against overall positive impacts
Freedom of Information Act (2000) status	◉ **This document is for full publication** ○ **This document includes FOIA exempt information** ○ **This whole document is exempt under the FOIA**

The purpose of this report is to provide the committee with an analysis of data within the maternity clinical dashboard for August 2018. The report highlights any elements by exception and indicates a description for the indicators that are not aligned with local or national targets below:

1. **Telford Consultant Unit Births**. The expected locally set range for this descriptor is between 300-350 births per month. August 2018 has seen a live delivery figure of 344 (88.2%). This is above the national target of 86.6%.
2. **Midwife led unit Births** – The expected locally set range for this descriptor is 2-50 births per month depending on the MLU. The overall numbers of births in the five Midwife-Led units were 37 births in 2018 (11.5 %). The National MLU birth figure is 11.8%. Bridgnorth, Ludlow and Oswestry MLU were all suspended to births and postnatal inpatient stays during August 2018 and Shrewsbury MLU has reduced capacity (whilst building works continue). However the birth in these units for August 2018 were:-

- Wrekin had 27 births
- Shrewsbury 9 births

The Home births for August 2018 were 9 births (2.3%), this is above the national rate set by the NMPA data of 1.4%. There was one BBA in August (0.3%)

3. **Rate of Vaginal Birth after Caesarean Section (VBAC).** The rate of successful vaginal birth after a single previous caesarean section is a Clinical Quality Improvement metric. The expected NMPA rate for this descriptor is 57.7%. The Maternity rate in August 2018 for VBAC is 19.4 %. This rate will be observed going forward.
4. **Smoking at Time of Delivery-** The expected National figure is 11.7%. The Maternity SaTH rate for August 2018 is 15.4 %. A Public Health Midwife has been in post for sixteen months (financed by Telford and Wrekin Council and CCG), who continues to concentrate on the Telford and Wrekin pregnant smoking population to change habits and drive down this figure.
5. **Percentage of Babies born at less than 2500gms**. This is a National Maternity Indicator. The expected GIRFT rate for this descriptor is 2.3%. The Local SaTH data for August 2018 was 6.4%. Moving forward we will be monitoring this closely.
6. **Babies Breast Feeding at Discharge from Midwife to Health Visitor.** This is an additional maternity metric not measured prior to 2018 by SaTH. Although initiation rates are excellent there appears to be a drop off around discharge from the unit. The NMPA rate is 68.1% SaTH rates have been measured at 46.4% for August 2018. This has been brought to the attention of the Infant feeding coordinator and a plan to bring this back in line will be made.
7. **Induction of Labour Rate**. This is a maternity metric. The NMPA expected rate is 28.5% The SaTH Maternity rate is reported as 38% in August 2018. This has reduced from the previous month of 43%. The education of women around reduced fetal movements has played a part in this increase. This rate will be observed going forward to identify any further increases and trends.
8. **Maternal Outcomes –Caesarean section rate**. This overall rate set by the NMPA is 25%. The rate of 20.6% for August 2018 is below this rate.
9. **Stillbirth –** The MBBRACE expected rate was 0.38% (2015). The local rate for August 2018 was 0.3% (one case). There have been a total of eleven stillbirths in the 2018 Calander year which is a reduction on the previous 2017 year.
10. **Access to screening services** % of bookings with a gestation of less than 10 +0 weeks. This KPI' submission data is collected to inform PHE England and the Regional Screening Board on the Trisomy 13 and 18 rates. The screening Midwife Specialist submits this data monthly. The National and regional target for this screening is 50% as the acceptable standard with an aim of 75%. This target is a QA standard set by NHS England. The figure

for August 2018 figure was 65.2% based on LMP. The validated figure can be as much as 20% below. The previous poor rate during 2017/18 was raised by the national screening programme board and has been added to the Women and Children's risk register (current score 16).

11. **Access to maternity services** - % of bookings with a gestation of less than 12 weeks and 6 days. The expected National set range for this descriptor is 90-100%. The rate for August 2018 was 86.7% 2018. Regular booking meetings are taking place to look at ways of improving these figures.

12. **Antenatal Bookings**- The local expected rates for antenatal bookings are 400-450 per month. During August 2018 there were 422 bookings.

13. **Hypoxic Ischemic Encephalopathy (HIE) –** This data is collected on the neonatal IT system "Badger net" and is now a feature on the Clinical maternity Dashboard from June 2018. HIE is graded into three categories.

HIE Grade 1 Mild

- Muscle tone may be slightly increased and deep tendon reflexes may be brisk during the first few days
- Transient behavioural abnormalities, such as poor feeding, irritability, or excessive crying or sleepiness (typically in an alternating pattern), may be observed
- Typically resolves in 24h

HIE Grade 2 Moderate

- The infant is lethargic, with significant hypotonia and diminished deep tendon reflexes
- The grasping, Moro, and sucking reflexes may be sluggish or absent
- The infant may experience occasional periods of apnoea
- Seizures typically occur early within the first 24 hours after birth
- Full recovery within 1-2 weeks is possible and is associated with a better long-term outcome

HIE Grade 3 Severe

- Seizures are usually generalized, and their frequency may increase during the 24-48 hours after onset, correlating with the phase of reperfusion injury.
- Stupor or coma is typical; the infant may not respond to any physical stimulus except the most noxious.
- Breathing may be irregular, and the infant often requires ventilatory support
- Generalized hypotonia and depressed deep tendon reflexes are common
- Neonatal reflexes (eg, sucking, swallowing, grasping, Moro) are absent
- Disturbances of ocular motion, such as a skewed deviation of the eyes, nystagmus, bobbing, and loss of "doll's eye" (ie,conjugate) movements may be revealed by cranial nerve examination
- Pupils may be dilated, fixed, or poorly reactive to light
- Irregularities of heart rate and blood pressure are common during the period of reperfusion injury, as is death from cardiorespiratory failure

There is one reported HIE during August 2018 demonstrating 0.3%.

Maternity Clinical Dashboard - 2018/19 - All SaTH Activity

The Shrewsbury and Telford Hospital NHS Trust

No	Indicator	Descriptor	APR	MAY	JUN	Q1	JUL	AUG	SEP	Q2	YTD
1	CQUIM - Clinical Quality Improvement Metrics	Smoking rate at booking	17.6%	20.6%	16.6%	**18.5%**	18.8%	16.6%	16.9%	**17.4%**	**17.9%**
		Normal birth rate	69.9%	68.7%	68.4%	**68.9%**	65.1%	66.7%	71.9%	**67.9%**	**68.4%**
		Caesarean section delivery rate in Robson group 1 women	8.5%	3.6%	12.4%	**8.2%**	4.7%	8.9%	12.5%	**8.4%**	**8.3%**
		Caesarean section delivery rate in Robson group 2 women	28.2%	26.2%	21.3%	**25.0%**	30.2%	20.3%	18.1%	**23.2%**	**24.1%**
		Caesarean section delivery rate in Robson group 5 women	25.4%	28.6%	29.2%	**27.9%**	34.9%	30.4%	25.0%	**30.4%**	**29.1%**
		3rd and 4th degree tear rate among women delivering vaginally	2.2%	3.4%	3.6%	**3.1%**	1.7%	3.0%	3.3%	**2.7%**	**2.9%**
		Rate of postpartum haemorrhage of 1500ml or greater	1.4%	1.7%	1.3%	**1.5%**	2.9%	1.6%	2.7%	**2.4%**	**1.9%**
		Rate of successful vaginal birth after a single previous caesarean section	27.3%	32.4%	40.0%	**34.1%**	28.6%	19.4%	43.3%	**30.1%**	**32.0%**
		Smoking rate at delivery	14.0%	17.2%	16.1%	**15.9%**	15.6%	15.4%	15.2%	**15.4%**	**15.6%**
		Proportion of babies born at term with an Apgar score <7 at 5 minutes	0.3%	0.8%	0.8%	**0.7%**	0.3%	0.6%	0.8%	**0.6%**	**0.6%**
		Proportion of babies born at term admitted to the neonatal intensive care unit	16.2%	17.0%	16.6%	**16.6%**	18.9%	20.0%	16.0%	**18.3%**	**17.4%**
		Proportion of babies readmitted to hospital at <30 days of age									
		Breastfeeding initiation rate	76.5%	76.6%	78.6%	**77.3%**	76.3%	74.7%	73.4%	**74.8%**	**76.0%**
2	National Maternity Indicators (NMI); Domain 1: Mortality and morbidity	Stillbirth rate	0.3%	0.7%	0.0%	**0.3%**	0.0%	0.3%	0.3%	**0.2%**	**0.3%**
		Neonatal Mortality Rate									
		Brain injuries - HIE	0.0%	0.0%	0.0%	**0.0%**	0.3%	0.3%	0.0%	**0.2%**	**0.1%**
		Proportion with singleton term infants with a 5-minute Apgar score of less than 7	0.3%	0.8%	0.8%	**0.7%**	0.3%	0.6%	0.8%	**0.6%**	**0.6%**
		Proportion of vaginal births with a 3rd/4th degree perineal tear	2.2%	3.4%	3.6%	**3.1%**	1.7%	3.0%	3.3%	**2.7%**	**2.9%**
		Proportion of birth episodes with severe PPH of greater than or equal to 1500ml	1.4%	1.7%	1.3%	**1.5%**	2.9%	1.6%	2.7%	**2.4%**	**1.9%**
3	National Maternity Indicators (NMI); Domain 2: Clinical care and health promotion	Normal birth rate	69.9%	68.7%	68.4%	**68.9%**	65.1%	66.7%	71.9%	**67.9%**	**68.4%**
		Caesarean section delivery rate in Robson group 1 women	8.5%	3.6%	12.4%	**8.2%**	4.7%	8.9%	12.5%	**8.4%**	**8.3%**
		Caesarean section delivery rate in Robson group 2 women	28.2%	26.2%	21.3%	**25.0%**	30.2%	20.3%	18.1%	**23.2%**	**24.1%**
		Caesarean section delivery rate in Robson group 3 women	2.8%	0.0%	2.2%	**1.6%**	1.2%	0.0%	4.2%	**1.7%**	**1.7%**
		Proportion of infants who are small-for-gestational-age (birthweight below 10th centile) (singletons)									
		Percentage of babies < 2500g	6.8%	7.9%	4.8%	**6.5%**	8.2%	6.4%	5.7%	**6.8%**	**6.6%**
		Proportion of live born babies who are breastfed for the first feed	69.3%	70.8%	70.2%	**70.1%**	66.9%	64.0%	64.6%	**65.1%**	**67.6%**
		Proportion of births between 23+0 and 27+6 which occur outside of a hospital with a neonatal intensive care unit	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
4	Other metrics not included in CQIM or NMI	Episiotomy rate overall	10.0%	14.8%	8.7%	**11.3%**	14.0%	14.1%	11.2%	**13.1%**	**12.2%**
		Overall assisted birth rate - Primip	16.0%	17.9%	18.1%	**17.3%**	19.6%	19.7%	15.1%	**18.3%**	**17.8%**
		Overall assisted birth rate - Multip	1.8%	1.2%	2.0%	**1.7%**	4.3%	3.8%	2.1%	**3.4%**	**2.5%**
		Skin to skin contact within 1 hour of birth	99.4%	99.3%	100.0%	**99.6%**	100.0%	99.7%	99.7%	**99.8%**	**99.7%**
		Babies breastfeeding at discharge	48.2%	47.6%	44.7%	**46.8%**	42.3%	46.4%	43.9%	**44.2%**	**45.5%**
		Shoulder Dystocia rate	0.0%	0.7%	0.5%	**0.4%**	1.5%	0.0%	1.3%	**0.9%**	**0.7%**
		Induction of labour rate	38.4%	37.0%	37.0%	**37.4%**	43.0%	38.0%	37.8%	**39.6%**	**38.5%**
		Rate of 1:1 care in established labour	98.0%	95.2%	96.1%	**96.4%**	97.7%	98.0%	98.3%	**98.0%**	**97.2%**
		Percentage of deliveries from mothers with placenta-praevia and abruption (spontaneous, unassisted vaginal delivery)	0.0%	0.2%	0.0%	**0.1%**	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
5	Births activity by Unit	**Overall Trust total births**	355	418	396	**1169**	390	390	385	**1165**	**2334**
		Telford Consultant Unit	300	372	347	**1019**	354	344	356	**1054**	**2073**
		Bridgnorth MLU	1	3	0	**4**	0	0	0	**0**	**4**
		Ludlow MLU	3	0	0	**3**	1	0	0	**1**	**4**
		Oswestry MLU	3	0	1	**4**	0	0	0	**0**	**4**
		Shrewsbury MLU	7	3	4	**14**	3	9	1	**13**	**27**
		Wrekin MLU	35	28	31	**94**	24	27	24	**75**	**169**
		BBA/Other	1	1	1	**3**	1	1	2	**4**	**7**
		Home	5	11	12	**28**	7	9	2	**18**	**46**
		% of births in Consultant Unit	84.5%	89.0%	87.6%	**87.2%**	90.8%	88.2%	92.5%	**90.5%**	**88.8%**
		% of birth in a MLU or at home	15.2%	10.8%	12.1%	**12.6%**	9.0%	11.5%	7.0%	**9.2%**	**10.9%**
		% of births in any MLU	13.8%	8.1%	9.1%	**10.2%**	7.2%	9.2%	6.5%	**7.6%**	**8.9%**
		% Home Births	1.4%	2.6%	3.0%	**2.4%**	1.8%	2.3%	0.5%	**1.5%**	**2.0%**
		% BBA/Other	0.3%	0.2%	0.3%	**0.3%**	0.3%	0.3%	0.5%	**0.3%**	**0.3%**
6	Operative Deliveries	Overall Assisted Births rate %	7.7%	8.0%	7.9%	**7.9%**	10.3%	10.9%	6.9%	**9.4%**	**8.6%**
		Forceps rate %	6.3%	6.1%	4.8%	**5.7%**	6.9%	6.0%	5.9%	**6.2%**	**6.0%**
		Ventouse rate %	1.4%	1.9%	3.1%	**2.2%**	2.9%	4.7%	1.1%	**2.9%**	**2.5%**
		Dual Instruments rate %	0.0%	0.0%	0.0%	**0.0%**	0.5%	0.3%	0.0%	**0.3%**	**0.1%**
		Caesarean Section rate %	20.3%	20.4%	22.7%	**21.2%**	22.7%	20.6%	19.1%	**20.8%**	**21.0%**
		Primip Caesarean Section rate %	22.9%	21.4%	27.8%	**23.9%**	26.4%	17.9%	22.3%	**22.0%**	**22.9%**
		Multip Caesarean Section rate %	17.4%	19.8%	19.8%	**19.0%**	20.3%	22.7%	17.3%	**20.0%**	**19.5%**
		% of Deliveries - Category 1 C/Section	1.7%	2.4%	2.8%	**2.3%**	2.4%	1.6%	1.1%	**1.7%**	**2.0%**
		% of Deliveries - Category 2 C/Section	8.3%	5.6%	7.4%	**7.0%**	7.1%	5.5%	8.0%	**6.8%**	**6.9%**
		% of Deliveries - Category 3 C/Section	1.7%	2.7%	0.3%	**1.6%**	1.6%	2.6%	2.4%	**2.2%**	**1.9%**
		% of Deliveries - Category 4 C/Section	8.9%	10.0%	12.2%	**10.4%**	12.1%	10.9%	7.7%	**10.3%**	**10.3%**
7	Access to Maternity Services	Number of Bookings	476	494	368	**1338**	362	422	414	**1198**	**2536**
		% of bookings with a gestation of less than 10 weeks	54.6%	64.6%	62.0%	**60.3%**	64.9%	65.2%	64.3%	**64.8%**	**62.4%**
		% of bookings with a gestation of less than 12 weeks 6 days	85.5%	85.4%	85.3%	**85.4%**	87.3%	86.7%	83.8%	**85.9%**	**85.6%**